

Community Health Assessment 2008/09

South Eastman Community Report



South Eastman Health/South East Inc.

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Courtyard, Bethesda Place, Steinbach.

**Be the change that you want
to see in the world. – Gandhi**



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2008/09 Community Health Assessment At a glance

When health care in Manitoba was regionalized more than a decade ago, community health assessment (CHA) was mandated as a key part of regionalization. Its purpose is to ensure that decision-making and planning by regional health authorities (RHA) are guided by scientific evidence on health and factors influencing health in the regional population.

For South Eastman Health/Santé Sud-Est Inc., the community health assessment is the cornerstone of this regional health authority's commitment to accountability and inclusion in health planning. The RHA Board of Directors is firmly committed to health planning founded on and directed by CHA evidence. The CHA process recognizes that statistics alone cannot paint a complete picture of the population's health since many community realities are simply not reflected in numbers.

The 2008/09 CHA, the region's third update since 1997, therefore has two equally important components: the statistical report, which describes a wide range of indicators of population health status and health determinants, and the report on consultations held with regional communities. That report describes information provided directly by community members to further the RHA's understanding of circumstances that shape the reality of people's lives and health.

CHA findings: statistics

South Eastman is a mid-sized rural health region with a relatively young population numbering just over 65,000. By far the fastest growing area of Manitoba, South Eastman has seen a 25 percent population



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Churches play strong community roles, with 70 percent of young families reporting regular church attendance.

increase between 1998 and 2008, compared to five percent for the province overall. This represents a gain to the region of more than 13,000 residents, greater than the population of its largest community, Steinbach. Substantial population increases have occurred in all regional planning districts and across all age groups. Not surprisingly, funding levels to support South Eastman health services continue to play constant catch-up with population growth.

Immigration has shaped South Eastman's makeup for more than 100 years. Now its society reflects a rich and varied cultural mosaic. Today recent immigrants account for nearly 10 percent of the population and represent at least 40 countries of origin and 25 languages.

In common with rural Manitoba generally, socio-economic levels in South Eastman are relatively modest. While employment rates consistently exceed Manitoba averages, incomes fall below provincial means across many municipalities, and education levels are noticeably lower than in Winnipeg, even among younger adults.

High levels of social capital and strong community networks are characteristic of South Eastman. Families score their communities well above national averages in safety, quality, social support, and stability. Churches play strong community roles, with 70 percent of young families reporting regular church attendance.

Health status in South Eastman continues to be among the best in Manitoba, with life expectancies above provincial averages for both women and men. Nevertheless, relatively good health is not shared equally across the region. The greatest burdens of illness on the population are chronic physical diseases (such as diabetes, arthritis, cancer, cardiovascular

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disease, and lung disease) and mental illnesses (including anxiety, mood disorders, schizophrenia, eating disorders, and substance abuse). While such physical and mental disorders are generally viewed as problems that accompany aging, their foundations are set very early in life. The CHA highlights vulnerabilities in South Eastman's early childhood population and provides strong evidence of risk factors and early health problems among youth and young adults.

CHA findings: community consultations

Over time, the CHA has conferred widely with South Eastman communities, reporting consultations on the health of men, the health of women, population health and literacy, and health care at the end of life. Many South Eastman residents – almost one in every 50 – have contributed their first-hand knowledge and experiences of health to a CHA.

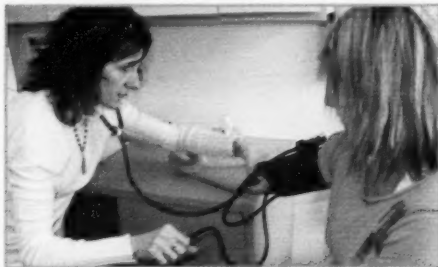
In 2008/09, following more than a decade of regionalized health care and considerable population change, it was important to re-appraise the fundamental health services provided in the region. Consequently, the South Eastman CHA undertook a series of community consultations on primary health services; that is, familiar, basic, local health services – those that most people need most of the time and where they turn first when they have health problems or questions. The consultations on primary health services were extensive, engaging community residents, regional physicians, and RHA staff throughout all South Eastman districts.

This CHA also consulted a number of unique South Eastman communities to give residents opportunities to voice concerns on specific health and health care



Health status in South Eastman continues to be among the best in Manitoba, with life expectancies above provincial averages for both women and men.

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It is clear from the full range of consultations that primary (basic, local) health services are the leading issues for all South Eastman communities.

I think we're very blessed with the care that we have.

We have a great basis.... What we are doing, we are doing well... We don't have to take a back seat to anyone.

We need to work on getting the basics better first.

There's no such thing as a family doctor any more. You're a number and that's all there is to it. If they tell you to go to a walk-in clinic, then that's what you do.

needs. These populations include Métis communities, older adults, and youth and young adults.

It is clear from the full range of consultations that primary (basic, local) health services are the leading issues for all South Eastman communities. Community perspectives also highlight the special challenges that South Eastman faces in delivering primary health services: its steadily increasing population, correspondingly shrinking resources, and ever-rising demands and pressures on all aspects of service delivery. Hearing and documenting the community experience has provided crucial first-hand information from health system users to guide the RHA's short- and long-term health planning.

Communities tell us

First and foremost, regional communities believe that the RHA is working from a solid service foundation. Residents and health providers alike highly value South Eastman's primary health service system, citing its responsiveness, the quality of care provided, and the working environment it offers physicians and RHA staff.

At the same time, South Eastman communities perceive that the region needs to make considerable inroads in three broad areas: strengthening local health services; improving collaboration and service coordination; and responding to the unique needs of special populations.

In terms of strengthening local health services, the leading community priority is achieving greater continuity of physician care. Residents feel strongly that they want more consistent medical care from physicians who know and understand them. Communities ask the

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RHA to work to increase physician numbers, reduce physician turnover, and improve access to medical clinic hours.

Communities see better information and communication as another key factor in strengthening local health services. Residents ask for easy-to-find information on health services available in South Eastman. They want ready access to health information and answers to health questions so they can make independent decisions and better manage their own health. The RHA is encouraged to make greater use of technology and other methods of communication, including internet, email, and community newsletters. The health system is also urged to improve communication among service providers which, to residents, often seems disjointed and fragmented.

Communities also believe that it is extremely important to strengthen South Eastman's mental health services. Enhancements should include access to a wider range of services such as addictions treatment, which is not readily accessible to many rural residents in need, and improved response to mental health crises. Communities also call for better communication between the mental health program and physicians and for increased public and provider awareness of the mental health services currently provided in the region.

South Eastman communities perceive a critical need to improve coordination and collaboration within the regional primary health service system.

One of the major barriers to service access and satisfaction is the complex nature of the health system, which many people find confusing, impersonal,

Information . . . to be guided . . . to know where to start. Getting help is like a gift.

Knowing who to call when we have an issue. Do we call our GP? Or do we call someone else in authority that can direct you this way or that way? Maybe you can wait a couple of days because it sounds like you just have a cold.

One of the things we need in our region is some specialized services for kids that are addicted to street drugs . . . If they want to get off of drugs they have no place to go . . . I don't think that's an easy task to fulfill, but it's urgent. All of our communities are affected by drugs in one shape or form.

I have told people about this [mental health] service. . . It is right here. It is like a hidden treasure.

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You don't know where to call. So you call one office and they give you another number to call. Then, either no one answers or they refer you back to the first office!

A patient will come to the facility but they don't even know why they are there. They just know that they have an appointment.

There are a number of health issues that could be dealt with by a nurse . . . It doesn't need to be a doctor all the way through.

Some of the things that we are doing as physicians, we could spend our time more effectively doing other stuff.

The doctor's office closes at five, and you quit work at five.

I foolishly assumed that there were records and that they shared them. When she came to Steinbach for follow-up, I asked them if they had the records and they didn't. We had to do the tests all over again. How can they help the whole person if they only have half the picture?

If I have a mental health question, I don't have to be talking to my physician, but he can connect me with a mental health worker. Right now, you can go see a different doctor and no one knows; a different specialist and no one knows what the other one has done to you.
This is silly and a waste of resources.

and intimidating. Communities ask for processes to make navigation of the local health care system easier by helping to coordinate information, communications, and the logistics of accessing care.

South Eastman communities also advocate for innovative ways of delivering primary health services, focusing on greater service collaboration and coordination and alternatives to physician care. Residents and providers are highly supportive of new and different service models and structures, including greater use of nurse practitioners and other non-physician providers and more flexible hours of operation.

In addition, residents and health providers stress the need for the local health system to make client information accessible across the full range of health care settings. They urge the RHA to move towards universal electronic health records to streamline information-sharing, increase efficiency, and improve client care and the health care experience.

Primary health services are also leading concerns for the special communities consulted as part of the 2008/09 CHA, with residents' comments and recommendations mirroring those documented in the other consultations. For these communities, however, statistical and other research data point to particular health concerns requiring focused attention.

Residents of special communities provide South Eastman with specific direction to address their unique health and health care needs. Métis communities encourage greater awareness of Aboriginal health issues and cultural influences on family and health. Older adults call for support and advocacy to foster independent living, including assistance with senior housing and

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transportation issues. Youth and young adults see the need for health services more responsive to their age group, including greater use of technology to provide health information and options for service delivery specifically targeted to young people.

Communities offer planning advice and recommendations

There was remarkable consistency in the planning guidance offered to the RHA by South Eastman communities.

- Re-examine how primary health services are delivered and by whom, both region-wide and to individual communities.
- Put the client at the centre of health services, so that services revolve around the needs of the client rather than the needs of the health care system. Consider the whole person, not simply the health condition.
- Be practical in finding ways to overcome challenges, including funding, geography, and barriers within the health system.
- Build on local services that communities view as successful.
- Acknowledge diversity and respond to the specific needs of different communities.
- Enhance local health promotion and illness prevention activities.
- Develop ways of more effectively informing residents and health care providers about the range and availability of services in the region.
- Consider new ways of delivering services, particularly to bring services closer to communities, e.g. mobile and itinerant services, the use of technology.



Youth and young adults see the need for health services more responsive to their age group, including greater use of technology to provide health information.

At a glance



The community says: Put the client at the centre of health services, so that services revolve around the needs of the client rather than the needs of the health care system.

- Look at alternatives to traditional, clinic-based medical care, e.g. nurse practitioners, primary health care centres.
- Strengthen the dialogue among stakeholders. Help communities, physicians, and RHA service providers work together to find solutions to the day-to-day challenges of delivering primary health services in the region.
- Develop a regional plan for primary health care over the long-term. Involve the community.

In closing

The 2008/09 CHA builds on earlier CHAs with updated and expanded information on the health of the South Eastman population. In addition, this CHA:

- broadens health data collection to encompass additional important population groups, including Métis residents, children, youth and young adults, and older adults;
- reports on extensive consultations with regional communities and health care providers to examine primary (basic) health services in South Eastman;
- confirms that demands for regional health services continue to rise, in keeping with ongoing, steady population growth.

The following chapters provide details of the statistical analyses and community consultations that are part of the 2008/2009 Community Health Assessment.

"If I was a decision-maker, I would put myself in the patient's shoes."

Chapter 1: Population profile

Overview

The region covers approximately 10,000 square kilometers, encompassing 10 rural municipalities, Buffalo Point First Nation, one city, two towns, a village, a number of small communities, and an unorganized territory.

South Eastman has experienced remarkable growth over the past decade, and population projections forecast continuing growth above the provincial average.

Recent immigration is a key driver of population growth, accounting for nearly 10 percent of the region's total population.

The South Eastman population is not affluent. While employment rates exceed provincial levels, incomes earned are generally below Manitoba averages. Education levels are lower than those in Winnipeg, even among younger adults.

Living standards within South Eastman are mostly in the lower to middle ranges. There is a marked income gradient, from lowest to highest, when moving from the south-east of the region to the north, particularly the north-west. Region-wide, a considerable number of residents suffer from severe economic hardship.

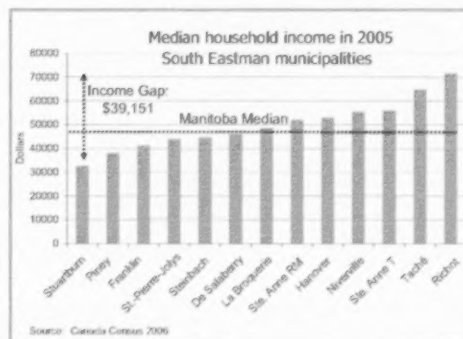
Demographics

Regional residents numbered 65,383 in June 2008, representing five percent of the Manitoba population and fourteen percent of rural Manitoba's population.

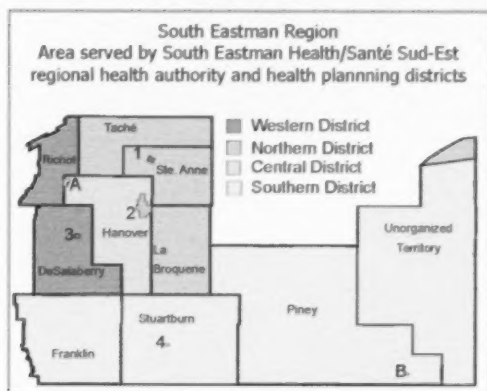
Within South Eastman, four geographic districts facilitate health planning:



The South Eastman population is younger than the general Manitoba population.



Chapter 1: Population profile



1. Ste. Anne Hospital
2. Bethesda Hospital (Steinbach)
3. DeSalaberry District Hospital (St. Pierre Jolys)
4. Vita and District Hospital
- A. Niverville Primary Health Care Centre
- B. East Borderland Primary Health Care Centre (Sprague)

- Western with 13,060 residents
- Northern with 17,220 residents
- Central with 29,141 residents
- Southern 5,962 residents

Overall, the South Eastman population is younger than the general Manitoba population, with a greater percentage of children under the age of 15 years (24 percent compared to 19 percent provincially) and a smaller percentage of seniors aged 65+ (10 percent vs. 14 percent).

There are marked differences in the age of the population among districts. In Central District the population is younger, with children representing 27 percent of its population and seniors comprising 10 percent. Conversely, Southern District has an aging population; seniors 65 years and older represent 18 percent of the population while children under age 15 represent 20 percent.

Ethnic and cultural characteristics

As in the rest of Manitoba, over 40 percent of South Eastman residents report multiple ethnic origins.

French as the home language was reported by eight percent of residents, with another one percent reporting both French and English. Eleven percent of South Eastman residents report non-official (neither English or French) languages used at home, with a further one percent using non-official languages in combination with English. Home language varies by district, with the use of French most common in Western and Northern districts and the use of non-official languages highest in Central District.

Nine percent of the region's population identifies itself as being of Aboriginal heritage, with 87 percent of these residents reporting Métis identity.

Chapter 1: Population profile

Around one percent of South Eastman residents belong to visible minority groups, compared to just under 10 percent of the overall provincial population. Visible minority residents in South Eastman increased 16 percent between 2001 and 2006, with the majority now residing in Central District.

Education

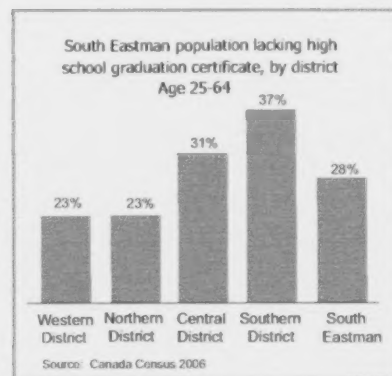
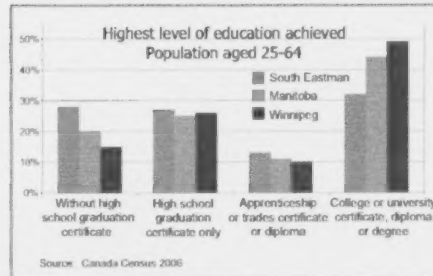
As in rural Manitoba generally, education levels are noticeably lower in South Eastman than in Winnipeg. More than 52 percent of residents aged 15 to 24 lack a high school certificate compared to 47 percent province-wide; 28 percent of residents aged 25 to 64 lack high school certificate compared to 20 percent province wide; and 61 percent of those aged 65 and older lack high school certificate compared to 46 percent province wide. There are marked differences across districts.

Employment and Income

Of South Eastman residents aged 15 and older, over 70 percent are in the labor force – 79 percent of men and 65 percent of women. Rates of employment and participation in the workforce are higher for South Eastman than the general Manitoba population.

The percent of South Eastman youth aged 15 to 24 in the labor force exceeds Manitoba averages for males and females. Unemployment rates for this age group are considerably lower than those Manitoba-wide.

Sixty-four percent of women with children under age six and 78 percent of women with children older than six years are in the labor force. Levels fell slightly between 2000 and 2005. While the 2006 census showed that 2,045 women with children under six



Chapter 1: Population profile

2005 Labor Force Activity Youth aged 15-24				
	Males		Females	
	South Eastman	Manitoba	South Eastman	Manitoba
Participation rate	74%	68%	69%	66%
Unemployment rate	4%	11%	7%	12%

years of age were in the labor force, the region had only 391 licensed child care spaces for pre-school children.

Income in South Eastman varies widely by municipality. Average employment income for the region generally falls below that for Manitoba. Women continue to earn less than men. Women who had full-time, full-year employment generally had an annual income that was around \$10,000 lower than that of men. This is consistent with the provincial figures.

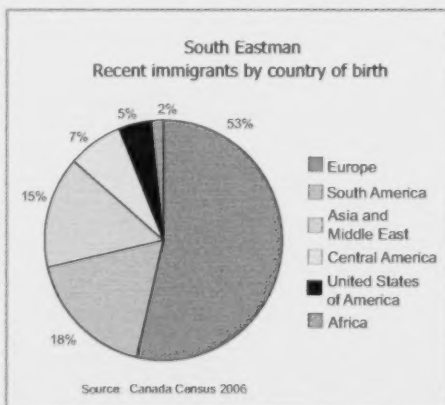
Compared to Manitoba averages, South Eastman workers are more likely to be employed in blue collar than white collar occupations.

South Eastman households on average spend a greater percentage of income on housing than the Manitoba average.

Immigration

In South Eastman, the contribution of recent immigrants to the population is higher than the Manitoba average; 2,200 recent immigrants have settled in the region. (A recent immigrant is someone who arrived between 2001 and Census Day 2006.) The previous Canada Census recorded that 1,355 recent immigrants settled in the region between 1996 and 2001. By 2006, one in fourteen South Eastman residents had arrived from overseas since 1996 compared to one in twenty-five for the overall Manitoba population.

While recent immigrants have settled across the region, 63 percent reside in Central District and another 23 percent in Northern District.



Chapter 2: Population health profile

Overview

This chapter describes the health of South Eastman residents using a wide range of indicators of population health status and population health determinants.

Data sources include statistics provided by Manitoba Health and Healthy Living, the Manitoba Centre for Health Policy, the Canadian Community Health Survey, and Statistics Canada, together with information routinely gathered by the RHA in South Eastman for monitoring and planning purposes. The data compare South Eastman to the rest of Manitoba and describe recent trends over time.

Health status

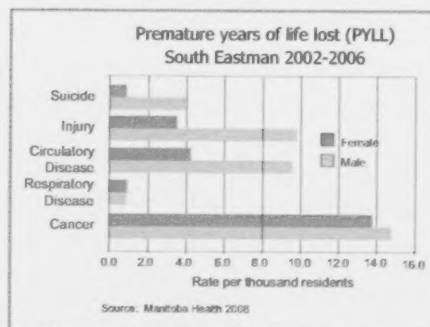
The health status of the South Eastman population remains among the best in Manitoba.

Life expectancy at birth is increasing with each passing decade. Although life expectancy is longer for women than for men in all Canadian jurisdictions, the gender gap is steadily narrowing. For both women and men in South Eastman, life expectancy is above average for Manitoba. Measured over the period 2001-2005, life expectancy at birth for South Eastman women was 83.2 years and 78.9 years for men, a difference of 4.3 years. The average life expectancy for all Manitobans measured in the same period was 81.5 for women and 76.3 years for men.

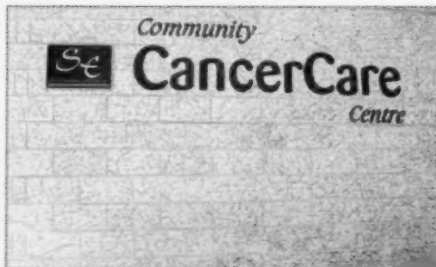
Cardiovascular disease and cancer are the leading causes of death across all southern Manitoba populations.



Only 21 percent of South Eastman residents aged 12 and older consider themselves "active", somewhat below the provincial average of 24 percent.



Chapter 2: Population health profile



Mental health disorders and chronic diseases, including cardiovascular disease, cancer, diabetes, and arthritis, account for the greatest burden of illness in the South Eastman population.

Compared to Manitoba overall, the South Eastman population demonstrates average to below average death rates and rates of major diseases and injuries.

Mental health disorders and chronic diseases, including cardiovascular disease, cancer, diabetes, and arthritis, account for the greatest burden of illness in the South Eastman population.

The prevalence (total cases) of South Eastman residents aged 10 and over diagnosed with mental health disorders was significantly below Manitoba averages in the periods 1996/97-2000/01 and 2001/02-2005/06. However, there was a significant increase in prevalence from the first to the second time period: from 20 percent to 22 percent.

Well-being

Indicators of well-being attempt to measure the extent of positive health. Well-being is more than being alive and being able to function; it implies a certain level of vitality and resistance to disease. People who feel well, for whom challenges are manageable and life is meaningful, are more able to cope successfully with stress and to remain healthy.

In common with most Manitobans aged 12 and older, residents of South Eastman generally report that they are healthy, coping, and functioning well. Among regional residents surveyed in 2005, 89 percent rated their own health as good, very good, or excellent. The majority of residents gave both their mental and physical health high ratings.

However, as in most areas of the province, 20 percent of South Eastman residents aged 15 and older report high stress in their lives and 45 percent report

Chapter 2: Population health profile

medium stress. Only 35 percent report that they experience no stress in their lives.

Seventy percent of South Eastman residents aged 12 and older report neither physical nor emotional difficulties that limited normal activities within the previous 30 days.

Overall, 40 percent of South Eastman residents are very satisfied with life, as are residents across Manitoba generally.

Health practices and lifestyle

Only 21 percent of South Eastman residents aged 12 and older smoked in 2005, a level slightly below average for the province. The proportion of former smokers was 41 percent. As in Manitoba generally, 15 percent of South Eastman residents reported exposure to secondhand smoke at home.

Approximately 42 percent of South Eastman adults aged 18 and older have acceptable weight, 38 percent are overweight, and 21 percent are obese. These figures match overall levels for Manitoba.

Like most Manitobans, less than 30 percent of South Eastman residents aged 12 and older eat five or more servings of fruit and vegetables per day as recommended by the Canadian Cancer Society and other health agencies.

Rating their leisure-time physical activity levels, only 30 percent of South Eastman residents aged 12 and older consider themselves "active", just above the provincial average of 29 percent.

Just over 30 percent of South Eastman residents aged 12 and older reported "heavy drinking", which is defined as consuming five or more alcoholic drinks at



In South Eastman, 94 percent of residents are satisfied or very satisfied with life.

Chapter 2: Population health profile



In South Eastman, 31 percent of seniors aged 65 and older live in non-family settings, while 27 percent of all seniors live alone.

one time. This level falls below the provincial average of 37 percent.

Rates of sexually transmitted infections reported for South Eastman residents are among the lowest in the province.

Coping and support

The social supports available to community members are extremely important factors in making them feel valued and in helping them to cope when problems arise.

There is a great deal of evidence that people with spouses/long-term partners live longer and are healthier than those without, the effect being far greater for men than for women. In South Eastman, 65 percent of residents age 15 and older are living in partner relationships, eight percent more than in the general Manitoba population.

People without partner support are, as a group, more likely to experience health problems over the long term. Indicators of social support therefore also include measures of need in two vulnerable population groups – lone parent families and non-family seniors.

Single parents head nine percent of all South Eastman families, below the provincial average of 17 percent. Men head 27 percent of the region's lone-parent families, more than the Manitoba average of 19 percent.

In South Eastman, 31 percent of seniors aged 65 and older live in non-family settings, while 27 percent of all seniors live alone.

South Eastman's Southern District lacks sufficient sheltered senior accommodation, that is to say, housing

Chapter 2: Population health profile

where the elderly can live independently yet have assistance close by if needed. Only seven percent of elderly person's housing units are located in Southern District, although the district is home to 16 percent of regional residents age 65 and older. At least 35 percent of the district's seniors live alone.

Social capital

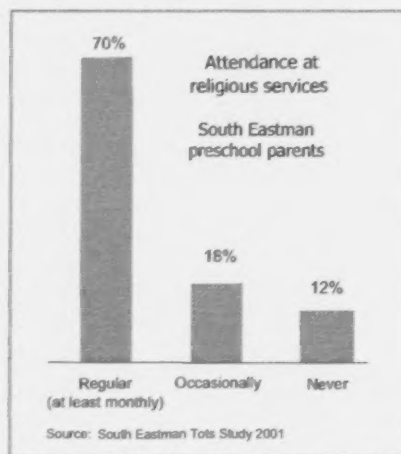
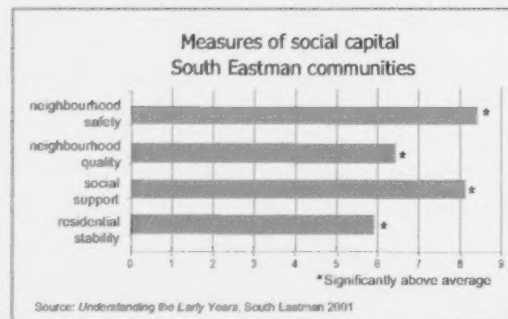
South Eastman families score their communities significantly above nation-wide averages in neighborhood safety, neighborhood quality, social support, and residential stability. South Eastman communities show evidence of strength and cohesion.

Churches play strong roles in South Eastman communities, with 70 percent of young families reporting regular church attendance. More than 110 churches serve 60 communities, large and small, scattered across the region. Without exception, they provide groups where members meet together through the week. Almost all have volunteers to assist members in need; provide programming for seniors, youth, and young families and counselling services for members in distress; make regular contributions to community food banks; and perform community benefit work – both at home and in other areas.

Health service use

South Eastman has approximately one family physician for every 1,700 residents. The average ratio for rural Manitoba served by RHAs is one family physician for every 1,500 residents.

South Eastman residents visit family physicians at rates below Manitoba levels, averaging just under five



Chapter 2: Population health profile



Three-quarters of all visits made by South Eastman residents to family physicians occur in the region.

visits per resident each year. Rates at which specialist physicians are consulted for South Eastman residents also falls below the provincial mean, as do rates at which regional residents actually visit specialists.

Three-quarters of all visits made by South Eastman residents to family physicians occur in the region. This varies by district. Central District residents receive over 90 percent of family physician services in the region. Northern and Western districts include communities close to Winnipeg, so 21 percent and 47 percent, respectively, of family physician services are provided in Winnipeg. Residents of Southern District receive nearly two-thirds of family physician services within region.

Hospitalization rates for South Eastman residents are on par with Manitoba averages. Approximately 50 percent of hospitalizations of South Eastman residents take place in regional hospitals, 45 percent in Winnipeg hospitals, and five percent in hospitals elsewhere.

Almost 70 percent of the days spent in hospital by South Eastman residents are spent in the region's hospitals with less than 30 percent in Winnipeg hospitals. Persons aged 65 and older account for nearly 40 percent of cases and two-thirds of all hospital days used by the South Eastman population.

The growing regional population aged 75 and older has led to a 49 percent increase in Home Care cases over the past decade. The average length of time regional clients receive Home Care services has increased substantially.

Chapter 3: Population growth and health services

Overview

Over the past 10 years, South Eastman has experienced a growth rate more than five times the provincial average. The region's 10 year annual growth rate averaged 2.5 percent per annum. Between 2006 and 2007, however, the population increased 3.5 percent; between 2007 and 2008 the increase was 2.9 percent.

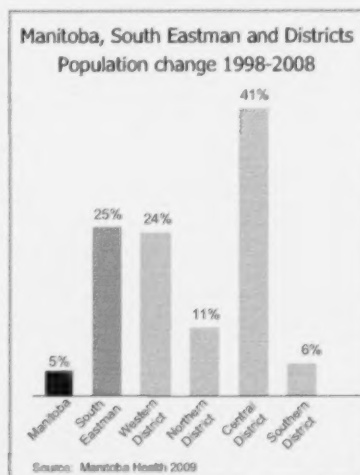
Funding for health services has not kept pace with the ever growing population. Over time, South Eastman's per capita funding relative to other regions has steadily declined. In 1999/00, per capita funding to South Eastman's RHA stood at 46.5 percent of the provincial average and 67.3 percent of the rural/northern average. By 2007/08, despite an 81.2 percent total funding increase since 1999/00, population growth had reduced South Eastman's per capita funding (\$991 per resident) to 43.2 percent of the provincial average (\$2,294 per resident) and 62.4 percent of the rural/northern average (\$1,588 per resident).

Growth has occurred over all districts but has been particularly strong in Central District, which has seen a 41 percent increase between 1998 and 2008 – approximately 8,500 additional residents – accounting for two-thirds of the region's growth.

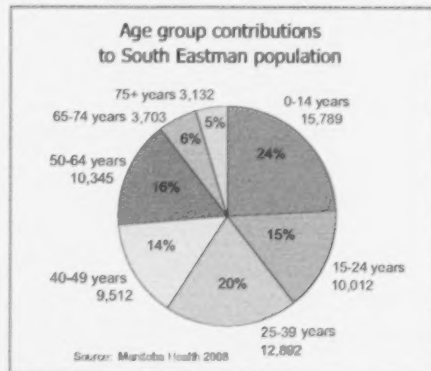
Growth well above provincial levels has also occurred across all South Eastman ages. Older age groups show very large increases, although residents under 40 years of age and those aged 40 years and older have contributed fairly equally to the region's



Funding for health services has not kept pace with the ever growing population.



Chapter 3: Population growth and health services



overall population growth. Central District has recorded dramatic increases across all age groups, while growth in other districts occurred primarily in the age group 40 years and older.

Growth in South Eastman is driven both by birth rate, which is above average, and immigration. While the majority of immigrants over the past decade are of German-Russian origin, the profile of overseas immigrants is gradually changing with increasing numbers coming from other areas of the world.

Of those who moved into the region between 1998 and 2008, 50 percent were under age 19. The vast majority settled in and around Central District. As a result, communities in these areas show very young age profiles. The 2006 Canada Census reported that the Rural Municipality of Hanover is now the third youngest rural community in Canada, with 31.6 percent of its population under age 15. The median age in Hanover is 27.4 years. Other South Eastman communities also show median age well below the Manitoba level (38.1 years), including La Broquerie (28.8 years), Niverville (30.8 years), and Steinbach (35 years).

Impact on regional health services

As a result of population growth, all South Eastman programs and services are experiencing significant and steady volume increases.

Public Health programs report 50 percent increase in births since 1999, 91 percent volume increase in childhood immunizations between 2002 and 2007, and a tripling of child health clinics in the regional centre, Steinbach. Public Health now delivers over 13,000 immunizations annually to regional children. Since

Chapter 3: Population growth and health services

2005, the number of child health clinics needed in Steinbach has increased from two or three days per month to eight to ten days.

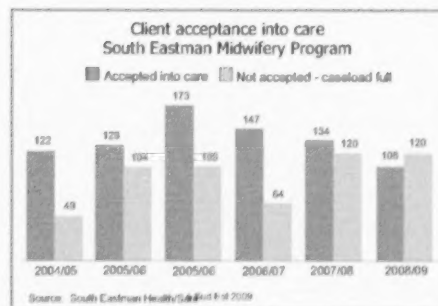
Demand for midwifery services outstrips resources, which led to an inability to accept 120 applicants in 2008/09. In that same period, 108 births were under the care of midwives. This accounted for 10 percent of births to South Eastman families.

Community Mental Health caseloads are rising steadily for adults, children and adolescents, the elderly, and intensive case management, resulting in caseload-staffing ratios exceeding provincial recommendations in all service areas. Adult caseloads, for example, increased 54% between 2004/05 and 2008/09.

Home Care caseloads have increased 48 percent over the past decade. The program has also seen increasing service intensity and lengthening of periods over which Home Care services are required.

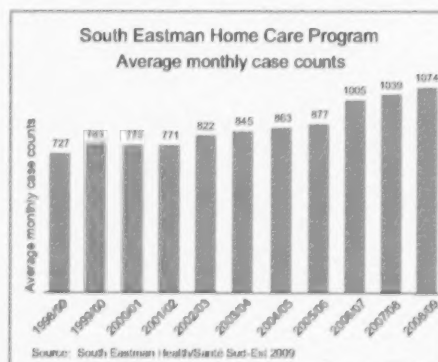
There are seven personal care homes (PCH) in South Eastman, accommodating 334 residents, three of which are associated with regional hospitals in St. Pierre-Jolys, Steinbach, and Vita. Three additional facilities, in Ste. Anne, Steinbach, and Grunthal, are not-for-profit, faith-based institutions, while the personal care home in St. Adolphe is privately operated.

The number of PCH beds allocated to South Eastman has remained fixed for more than 15 years. Consequently, the region's PCH bed supply (the ratio of PCH beds per 1,000 residents aged 75 and older) now falls below the provincial target of 110 beds

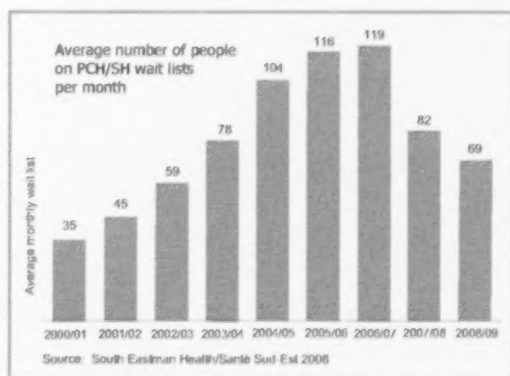
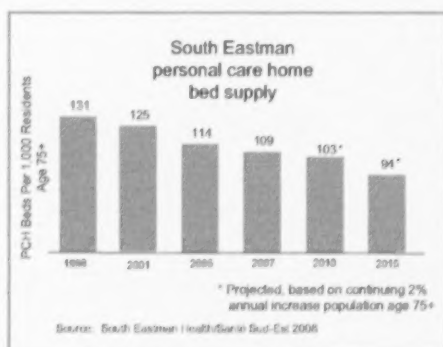


Community mental health caseloads in South Eastman		
Client group	Recommended ratio	Actual ratio
Adult	50:1	79:1
Child & Adolescent	35:1	43:1
Elderly	25:1	37:1
Intensive case Management	20:1	31:1

Source : South Eastman Health/Santé Sud-Est, 2008.



Chapter 3: Population growth and health services



per 1,000.¹ Given the decade-long trend of a steady two percent per annum growth in South Eastman's population aged 75 and older, the region expects an ongoing decline in the PCH bed supply to 103 per 1,000 by 2010.

Supportive Housing (SH), which offers care equivalent to light-level PCH, was introduced in South Eastman in 2002. In both 2007 and 2008 additional SH beds were funded bringing the total to 60 and the ratio to 20 beds per 1,000 residents aged 75 and older.

The average monthly wait list for PCH/SH more than tripled over the five years 2001/02-2006/07, from 35 to 119. In 2007/08, however, the opening of additional SH beds combined with increased deaths and discharges from PCHs saw the wait list fall dramatically. In 2008/09, the monthly wait list for PCH/SH averaged 69.

Family physicians contracted by the RHA are based in St. Pierre-Jolys and Vita. Fee-for-service family physicians practise in Niverville, Ste. Anne and Steinbach. In December 2008, South Eastman had the equivalent of 31.5 full-time family physicians. In addition, two general surgeons work from the hospitals in Ste. Anne and Steinbach, while the hospital in Steinbach is staffed by four emergency room physicians, two of whom also practise anaesthesia.

Family physician service volumes have risen 35 percent over the past 10 years. The burden of the increase has fallen largely on Steinbach family physicians, who account for two-thirds of services provided in-region and 90 percent of in-region services to Central District residents.

¹ Manitoba Health Strategic Directions and Provincial Drug Programs Division, Policy and Planning Branch, 2004.

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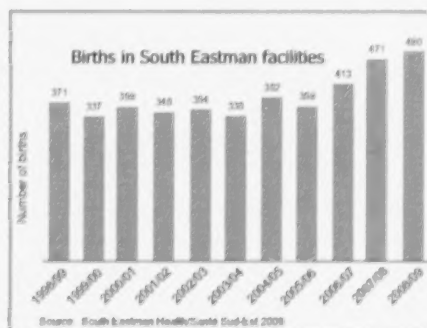
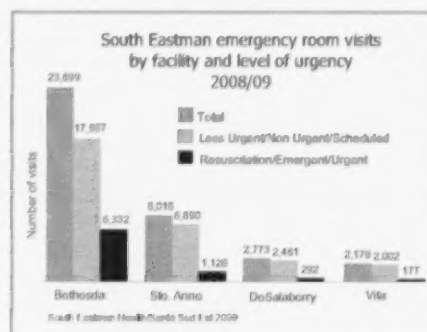
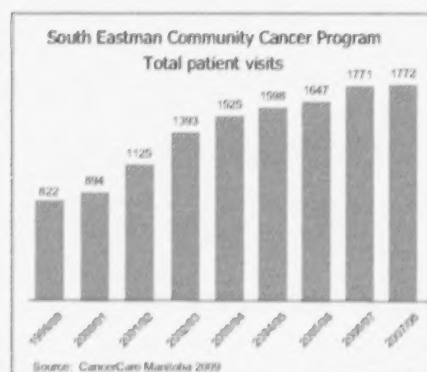
South Eastman has experienced marked and simultaneous increases in all high-user groups – infants, young children, women in the reproductive phase of life, and seniors aged 65 and older – leading to greatly increased demands for physician services.

South Eastman Health/Santé Sud-Est Inc. owns and operates the region's four hospitals, located in St. Pierre-Jolys, Ste. Anne, Steinbach, and Vita. In total, the region is funded for 129 acute care beds, including 20 extended treatment beds, yielding a ratio in 2008 of 1.97 acute hospital beds for every 1,000 residents. Acute care bed availability has declined steadily due to ongoing population growth; in 2002, the ratio was 2.22 beds per 1,000 residents.

All hospital-based services have experienced steadily increasing volume pressures. Particularly affected are emergency room, obstetrics, community chemotherapy, emergency medical services (EMS), and laboratory and diagnostic services.

Bethesda Hospital, Steinbach, has experienced a 40 percent rise in emergency room visits over the past 10 years. This facility provides two-thirds of emergency room services to South Eastman residents. Moreover, in recent years, severity levels have also risen sharply, with volumes of highest severity cases almost doubling over 2003/04 volumes. Meanwhile, levels of less severe cases (classified Less Urgent, Non Urgent, or Scheduled) have risen 15 percent.

Forty-five percent of births to South Eastman residents take place in regional hospitals, 50 percent in Winnipeg hospitals, and five percent at home or in hospitals elsewhere. Numbers are increasing for all locations and demands on South Eastman's obstetrical



Chapter 3: Population growth and health services



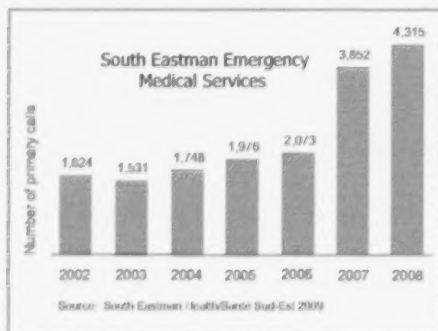
Births in South Eastman facilities rose 32 percent between 1998/99 and 2008/09.

services, provided by hospitals in Ste. Anne and Steinbach, are steadily growing.

Births in South Eastman facilities rose 32 percent between 1998/99 and 2008/09. Bethesda Hospital, which accounts for 80 percent of in-region births, saw 40 percent increase over the period, while births at Ste. Anne Hospital rose five percent.

Population growth has also significantly affected the use of laboratory and diagnostic services in South Eastman. At Bethesda Hospital, Steinbach, where the vast majority of such services are provided, the number of blood tests increased 30 percent between 2003/04 and 2007/08. Similar increases occurred at the facilities in Ste. Anne (40 percent) and St. Pierre (31 percent). In Steinbach, however, blood testing services for the principal medical clinic were transferred in May 2008 to a privately run laboratory, leading to a steep fall (33 percent) in blood tests performed by Bethesda Hospital in 2008/09. This allowed for relocation of laboratory staff to other high-demand areas. Between 2007/08 and 2008/09, blood tests performed at Ste. Anne and Vita hospitals continued to rise, by three percent and six percent, respectively.

Highly significant volume increases have been experienced by the regional Emergency Medical Services (EMS) program. Primary ambulance responses rose 28 percent between 2002 and 2006 and more than doubled between 2006 and 2008. Primary response volumes are now almost three times the level recorded for 2002.



Chapter 4: Health in special South Eastman populations

The health of populations varies considerably according to age and gender, social and economic conditions, the physical environment, and access to quality health services. There are many ways in which these factors interact to influence health and health care.

The community health assessment examines not only health in the overall South Eastman population but also the health of specific groups in the region. For these special groups, the CHA gathers statistical information and consults directly with community members through focus and discussion groups. This helps further the RHA's understanding of circumstances that shape the reality of people's lives and health. Information from the CHA reports helps guide the regional health authority in policy-making and planning to address the health needs of these special groups.

The 2008/09 CHA update reports on the health experiences and needs of Métis communities; adults aged 55 years and older; youth and young adults aged 15-24 years; and the early childhood population aged 0-6 years.

The 2003/04 CHA update previously reported the unique health experiences and needs of women, men, and individuals nearing the end of life. It also studied the complex relationships between health and socioeconomic factors (education, employment, income) in a study of population health and community literacy.

From the 1997/98 CHA report, the regional health authority identified five priority vulnerable population



The health of populations varies considerably according to age and gender, social and economic conditions, the physical environment, and access to quality health services.

Chapter 4: Health in special South Eastman populations - Métis



In the 1996 Canada Census, the Aboriginal population represented five percent of the region's population, while in 2001 it was seven percent, with the Métis portion of that at 83 and 86 percent respectively.

groups: children and youth, seniors, women, socio-economically disadvantaged residents, and residents of the Southern District. Mental health and better accessibility to services were also identified as service priorities.

1. Métis communities

While a great deal of work has been done to describe the health of Canada's First Nations peoples, there is little information on the health of Métis populations. Within South Eastman, there are no research data specific to the health of local Métis communities or to the significance of acknowledging Métis heritage and culture in providing health services. To this point, most statistical information, such as that from the Canada Census, groups Métis within the Aboriginal category.

The consultations undertaken as part of the 2008/09 CHA provide important new information about health issues and concerns in South Eastman Métis communities, as well as recommendations to the RHA for ways of working with communities to improve health and health service delivery.

Statistical background

About eight percent of the overall South Eastman population identified themselves as having Métis heritage, according to the 2006 Canada Census. Just over three-quarters of the Métis in the region live in Northern and Western districts.

In the region, the Métis population, together with the overall Aboriginal population, shows continued growth. In the 1996 Canada Census, the Aboriginal population represented five percent of the region's

Chapter 4: Health in special South Eastman populations - Métis

population, while in 2001 it was seven percent, with the Métis portion at 83 and 86 percent respectively.

South Eastman's population of Aboriginal heritage is considerably younger than the overall regional and provincial populations, with a median age of 25 years in 2006 compared to 34 years in South Eastman and 38 years for Manitoba.

Almost half of the region's residents of Aboriginal heritage report speaking both French and English, compared to 18 percent of the overall regional population and nine percent of the provincial population.

Compared to the overall regional and provincial populations, South Eastman Aboriginal residents report similar rates of high school completion, but higher levels of apprenticeship and college certification and lower levels of university completion.

The region's Aboriginal population experiences income levels in line with provincial and regional averages. Unemployment rates are somewhat higher than overall for the region for both men and women but below the provincial rates.

Consultations with Métis residents

Métis residents taking part in the consultations perceived that their health issues were not specific to their Métis background but rather were similar to those of the broader community. At the same time, they were interested in more clearly understanding if and how their heritage may impact health.

Consultation participants observed the increasing trend among regional residents to identify Métis background, noting increased pride in a shared

Highest level of certificate, diploma or degree attained by population group					
	None attained	High school	Apprentice or trade	College	University
South Eastman Aboriginal	26%	28%	18%	21%	9%
Total South Eastman	37%	27%	10%	14%	12%
Total Manitoba	29%	27%	10%	15%	19%

Chapter 4: Health in special South Eastman populations - Métis

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If we had a clinic once a month where there would be a nurse who would be bilingual and you would know that it was open on [for example] the last Thursday of every month from 3 to 8, so people would know they could access that too . . . and then you would have an appointment to talk about different things that the doctor doesn't have time for. Or there would be a class on how to take care of your health and what to look for. At what age should you be worried about certain things? Like men for prostate cancer? And women for this? You know, teenage children – at what age should you be watching for different things? Or school age children, are they watching too much TV?

Like what we have in our Centre de la petite enfance, which is coordination of everything 0 to 6 years! But to have something like that for general health. To coordinate . . . It's not to reinvent the wheel, but it's to coordinate!

heritage with the Francophone community and diminished social stigma around Aboriginal ancestry.

Métis residents were generally satisfied with the quality of health services but raised concerns about the lack of information and awareness of services available locally and within the region. Concerns were expressed regarding lack of access to primary health care.

Recommendations

Métis residents identified four key themes for the RHA to consider for improvement.

1. Increase access to primary health services, particularly at the local level, and provide services differently.

Many residents feel that the notion of having a family physician who really gets to know them, understands their health history, and helps them with their health decisions is an ideal no longer possible to achieve. Increasingly, residents are forced to shop around outside their communities for physicians willing to see them and are driving long distances as a result. On occasions when they resort to using the services of hospital emergency rooms, they feel there is a less than welcoming reception.

It was pointed out by participants that the lack of access to primary care physicians represents more than just inconvenience; it stands in the way of health. Given the effort required to get appointments with often-unfamiliar physicians, many people put off seeking help for health problems, which risks disease progressing to levels more serious, difficult, and expensive to manage. Routine follow-up visits for common chronic health problems, such as high blood pressure and

Chapter 4: Health in special South Eastman populations - Métis

diabetes, are less likely to occur on schedule and opportunities for preventive health counselling are missed.

Residents felt that many of their health problems could be managed equally well, or better, by providers other than physicians, such as nurses, dieticians, or physiotherapists. They also felt strongly that the requirement for physician referral to access other health care providers presents serious barriers, often entailing delays and the need for self-advocacy.

Residents spoke of their desire for "one-stop health care" – community sites where health information is available and health education provided. As well, when residents require specific services, these need to be coordinated and the information integrated in one file, with follow-up centered on the person rather than scattered across separate problems. Residents see these changes as not only improving their health care but allowing them greater control over their health decisions and actions.

2. Strengthen the RHA's knowledge and awareness of Aboriginal and Métis identity, health and resources that are available for Aboriginal and Métis health.

It was felt by community and provider participants that there is growing need for the RHA to acknowledge residents of Aboriginal heritage and develop strategies to increase knowledge and understanding for staff and community members around Aboriginal health issues and how cultural influences impact family and health.

You need a place where you can access all resources through one coordinator or two, someone would tell you like here's a phone number, help navigate . . . to be able to do it yourself without having a referral to a physician.

I think that's a fairly new thing because I'm with XXX school division and in the fall 2006 we had a division-wide in-service (bus drivers and secretarial and central administration) at the Aboriginal education centre. And I thought it was ironic because people were saying who was Métis . . . and I would say roughly a third to a little more than a third of the employees in this division were – and this is the first time that actually anybody took a focus on that.

For our program, there are some provincial sessions . . . Sometimes those conferences have an Aboriginal piece of education, but I think it is something we struggle with. Where do you send the group, or even a whole team – Public Health, Nursing, and Home Visiting – for education? How can we educate them on Aboriginal needs?

Chapter 4: Health in special South Eastman populations - Métis

I think that a lot of the infrastructure is here. And it's working, and it's working well. It's just that they [RHA] have to be able to sell their product. It's kind of like "Get out there and let people know about it". People need to know what's available and where and when. For the most part, it's a phone call away . . . So it's almost like a marketing aspect.

I never knew you could access Mental Health Services in [my community]. I just assumed if you wanted counselling then you had to go to the city . . . If that information could be made available . . . I don't even know how accessible it is.

We don't have a place to go to get information. We have a public health nurse, and we have community health workers. You could have information on wellness and diabetic information. Like you have healthy baby clinic, you could have that for toddler clinic, or even parents with teenagers clinic.

I think the whole point is prevention. You don't wait until something happens. If your family physician knows there's a positive family history of heart disease, start from there, start teaching the kids. You deal with the parents, but you have to start prevention with the children.

There could be prevention in mental health. Going into the schools and making presentations and talking about it.

3. Improve information and awareness of RHA services, particularly related to mental health issues.

Residents feel strongly that there is need for more and better information about RHA services and how these are accessed. They believe that, if community members are better informed about services, they will be better equipped to make decisions and take individual responsibility for their health. Getting information out to other service providers was also seen as extremely important, especially to those who may be the first points of contact with community members, such as physicians and teachers.

In particular, participants expressed the need for greater awareness of existing mental health services and how to gain access. They also called for more services of a preventive nature, including educational outreach and early counselling. The desire for help in dealing preventively with mental health issues during adolescence was frequently mentioned, both for parents and for young people themselves.

4. Emphasize wellness and prevention.

While Métis residents were keen to promote local provision of medical services, they recognize that this will only address immediate health concerns. They also believe that ongoing focus on physicians and hospitals as the hub of health care encourages community notions that health services should be sought only in times of illness.

Participants advocated strongly for greater investment in the future health of their

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communities, with emphasis on wellness, not just illness, and preventive health services.

Maintaining wellness and preventing disease are seen as crucial for all ages. In all focus groups, there were lengthy discussions about the importance of working with families and with children and youth to help prevent future problems, particularly in the area of mental health. For adults, there were frequent references to early intervention for mental health problems and a great deal of interest in healthy living, lifestyle modification, and chronic disease prevention.

2. Older Adults (55+ years)

South Eastman is experiencing large and steady increases in numbers of older adults, including not only the age group 65 and older traditionally termed "senior", but also residents aged 55 to 64. Waiting in the wings is a growing number of residents aged 40 to 54. In South Eastman, the older adult population is increasing more rapidly than in the rest of Manitoba.

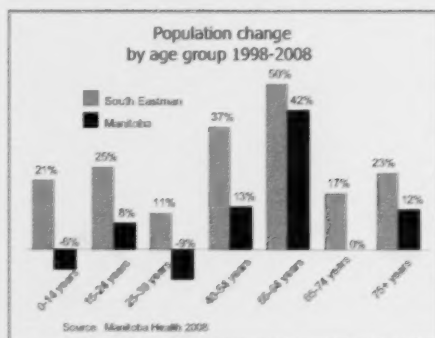
Health care delivery to older adults strives to prevent disease and manage chronic illnesses in ways that keep people well and independent in the community for as long as possible. This calls for the entire range of primary health services: health promotion; illness prevention; diagnosis and treatment; rehabilitation; and support.

For older adults, therefore, primary health services play vital roles in achieving and maintaining the best possible health and quality of life. Planning for optimal delivery of primary health services represents the



South Eastman is experiencing large and steady increases in numbers of older adults.

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health system's most pressing need in order to realize the best possible health outcomes for older adults.

Statistical background

Demographics

In South Eastman, the trend shows a large and steady increase in residents aged 55 and older, and this is expected to continue over the next decade. Comparatively, the population increase is dramatically higher than Manitoba averages for those aged 65 to 74 years and those aged 75 and older. The most rapidly growing group, aged 55 to 64, represents nearly half of older adult residents or more than nine percent of the region's total population.

The Manitoba Bureau of Statistics, in a study of provincial population projections 2006-2036, predicts that South Eastman will see at least a further 50 percent increase in the age group 55 to 64, while the age group 65 to 74 will grow by a factor of 1.5 and the group aged 75 and older will double in size.

Population distribution varies among districts, with adults aged 55 and older representing almost one-third of residents in Southern District compared to 18 to 19 percent of residents in each of the other three districts.

Standard of living

The vast majority of older adults in South Eastman live independently in the community. Of those 65 and older, around seven percent require institutional care – personal care home, supportive housing, or assisted living. Approximately 25 percent of the 65 and older age group lives in sheltered seniors' rental accommodation that may offer supports, such as the ability to purchase

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cleaning services or participate in congregate meal programs. Over two-thirds of individuals age 65 and older live in their own residences.

In South Eastman, 27 percent of residents aged 65 and older live alone, somewhat below the Manitoba average of 33 percent. There is variation within the region, ranging from 20 percent living alone in Northern District to 35 percent in Southern District.

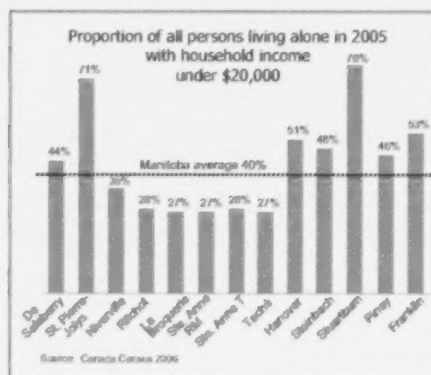
Only three percent of South Eastman residents aged 65 and older meet the Statistics Canada definition of low income, compared to 16 percent province-wide. However the proportion of South Eastman residents living alone who report household income under \$20,000 exceeds the 40 percent provincial average in seven regional municipalities and ranges above 70 percent in St. Pierre-Jolys and Stuartburn.

Education levels among South Eastman adults aged 55 and older are comparable to those across rural Manitoba but are considerably lower than for adults aged 20 to 54. The proportion of regional adults lacking a high school graduation certificate is 56 percent in the 55 to 64 age group and 75 percent among persons aged 65 and older.

Low education and literacy levels impact the ability of the older adult population to access, manage, and make decisions about health care. Many people with limited literacy skills do not know where to go for the health services they need. Lack of information, fear of embarrassment, low self-confidence, and limited resources often result in people with low literacy neglecting preventive care, failing to assert themselves, and waiting to seek medical help until a health problem has reached a crisis state.



The majority of older adults in South Eastman live independently in the community.



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Only 15 percent of people aged 65 to 74 and 21 percent aged 75 to 84 are hospitalized in the course of a year.

People with difficulty understanding complex materials frequently fail to understand directions on medication labels and make errors in the use of over-the-counter and prescription medications. They can also fail to follow medical directions because they can't read written instructions or because spoken instructions are given in such a way that they are too difficult to understand. In addition, low education and literacy levels can reduce the ability to understand the risks of medical procedures, while written consent forms, presented in technical language, may not meet requirements for informed consent.

Health services

Older adults are high users of health services as a group, but the most intensive health services are used by a minority of seniors aged 65 and older who experience poor health. The majority of seniors are well or relatively well and live independently in the community with varying levels of support.

Only 15 percent of people aged 65 to 74 and 21 percent aged 75 to 84 are hospitalized in the course of a year. Even among 85 year-old and older individuals, only one-third are hospitalized in a one-year period. A Manitoba study showed that only five percent of seniors aged 65 and older used nearly 80 percent of the hospital days consumed by this age group. Seniors using home care services range from just under 10 percent aged 65 to 74 to just over one-third aged 85 and older. Seniors living in personal care homes range from one percent aged 65 to 74 to just under one-third aged 85 and older.

Use of family physician services rises markedly with age, contributing to the regional trend of growing physician utilization. In the older adult group, healthy

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individuals account for the vast majority of physician services used. In other words, adults aged 55 and older generally make use of physician services for health maintenance and the prevention of serious illness.

In general, services like Home Care, Community Mental Health and Services to Seniors become increasingly important as the population ages. Eighty percent of Home Care clients are seniors aged 65 and older; two-thirds are seniors aged 75 and older. The use of regional Home Care services is steadily rising. Average monthly case counts increased 49 percent between 1997/98 and 2007/08.

South Eastman's Community Mental Health includes a specialized program stream, Mental Health Services for Older Adults, in which Community Mental Health workers work together with a consulting geriatrician to assist residents aged 65 and older who are living with mental health concerns and/or dementia. Demand for these services has increased steadily over recent years. Between 2004/05 and 2007/08, average caseloads for Mental Health Services for Older Adults tripled, from 30 to 90 clients per month.

The growing population of older adults also increases the need for primary health services, particularly around the prevention and management of chronic diseases. Incidences of many important diseases rise markedly with age – 75 percent of all cancers, for example, develop in people over 60. With seniors living longer than ever and the prevalence of cancer and other chronic diseases rising, the number of people living with these conditions is steadily increasing.



Little more than 50 percent of South Eastman residents aged 65 and older are immunized each year against influenza.

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I try to talk to my doctor, but then you are at the mercy of waiting for four, five, six, even ten days. They have a very long waiting list, and sometimes you just can't wait that long.

You see the doctor and all of a sudden, oops, they're not here anymore! Now who do you have? Who are you going to throw at us now?

It is the anxiety of getting seniors into their vehicles or trying to find someone to take them. Especially in a winter like this one.

I've sat for hours and hours and no one came near me. Finally, the girl would come and say, "The doctor is not coming in today. You can leave now."

The loneliness and the feeling of not being useful any more are very real in a lot of people.

Most of the time they just say, 'For more information, go to www . . .

They [seniors] don't have computers. I think [the RHA] needs to be very mindful of that. I don't think they are.

There is also evidence that current methods of giving prevention and health promotion information to older adults are not achieving their goals. For example, little more than 50 percent of South Eastman residents aged 65 and older are immunized each year against influenza; only 60 percent have received the recommended pneumococcal vaccine.

Consultations with older adults

Community consultations identified a number of barriers to health and health care among older adults, following several highly consistent themes.

- As with the community at-large, older adults see primary health services as centering on primary medical care.
- Older adults are generally satisfied with the health services available but are challenged by the lack of access to family physicians and related lack of continuity of physician care.
- Problems are compounded by geography, remoteness, and transportation.
- Health care workers are frequently perceived to lack understanding, empathy, and consideration in their dealings with aging clients and patients.
- Older adults face considerable hardships in maintaining independence while dealing with declining health, in some cases compounded by limited financial resources and social isolation, particularly as the years advance.
- As with other communities consulted, older adults request more information about, and better access to, the services offered in their community.

Chapter 4: Health in special South Eastman populations - older adults

Recommendations

The consultations provided a number of recommendations to the RHA on ways to work with communities to improve the health and health care experiences of older adults.

1. Anticipate the growing needs of an aging population.

While older adults generally appreciate the health services available in their communities, there is apprehension that, as the aging population continues to increase, they will be particularly vulnerable to systemic challenges, including shortages of health care workers and limited access to primary medical care. Older adults ask the RHA to plan for the growing needs of their age group and invest in more community-based resources for illness management and support.

2. Recognize transitioning needs.

The needs of older people increase with advancing age and their ability to maintain function at home depends greatly on assistance from family and community. Older adults stress the importance of engaging seniors and families in options before extensive services are required. They also see encouraging and supporting the community's responsibility for its oldest members as equally important.

3. Bring services closer to communities

Older adults perceive that making basic services available in local communities is practical and cost-efficient, for the health care system as well as for residents. They urge the RHA to consider

I like the direction things are going with aging in place and trying to keep people in the community as long as possible. A lot of the health care dollars go to institutions. It is all the high end care that gobbles up the dollars, so it would be nice to see more going to the front end, more preventive type of programming.

We just had a 'Living it up' in [community X] and it really went well. There were a lot of people that mentioned that they didn't know how to read labels. We also had an exercise session that had good reviews.

The RHA needs to continue working with the rest of the community on issues like transportation and housing. We could have regional committees that really start to work on things, instead of all of us just sitting around talking about it.

Chapter 4: Health in special South Eastman populations - older adults

I think that would be a good idea if we organized some place where we could meet monthly, and we could help each other out because running to your doctor is sometimes not the answer.

The materials for health promotion for older adults are really limited. Services to Seniors has expanded their role through community tenant resources to do a lot of health promotion . . . but the materials are very limited. I could see the RHA being more supportive in that area.

Make sure you have pleasant people; people who like older people. I remember my dad was so uptight because the worker got mad at my dad.

innovative ways of delivering basic services locally, including mobile and itinerant services and greater use of technology.

4. Focus health service planning and delivery on supporting older adults' independence.

Older adults asked the RHA for support and advocacy to help them live longer and remain independent in their own communities. This includes working with other community stakeholders on important issues surrounding the lack of senior housing and transportation.

5. Promote and enhance wellness.

Older adults see the need for greater efforts to maintain health and functioning for as long as possible. They asked the RHA for more resources dedicated to basic community-based health promotion and illness prevention activities in order to improve quality of life for older adults, as well as avoid the use of more costly health services and progress to institutional care.

6. Educate and orient health care personnel.

Older adults speak with great feeling of the importance of being able to access help from people who are empathetic to the challenges of aging. They asked the RHA to promote and facilitate provider awareness and sensitivity regarding older adults' limitations and needs.

7. Continue the dialogue.

Older adults encouraged the RHA to continue the dialogue with older adults and to actively involve them in planning and providing services in their communities, including mutual support for people living with chronic diseases and ways to encourage and help more residents to take part in existing activities.

Chapter 4: Health in special South Eastman populations - youth and young adults

3. Youth and young adults (15-24 years)

Young people, 15 to 24 years, form a key and growing segment of the South Eastman population. The years from age 15 to 24 mark an important developmental phase. Over time, the transition years from adolescence to adulthood have become increasingly complex.

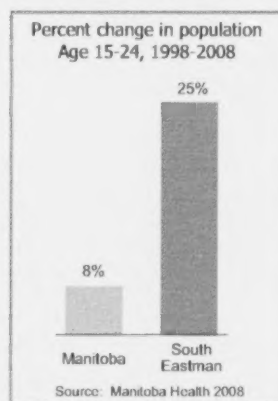
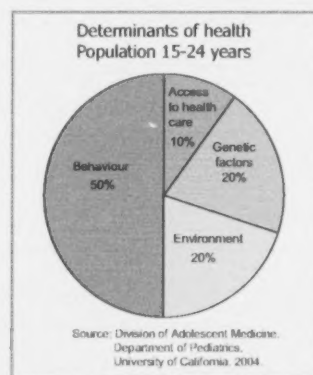
For today's young people, the traditional timing and sequencing of events that mark adulthood are less predictable and often prolonged and disordered.

A greatly changed labor market, calling for increased education and skills, delays their ability to achieve economic and individual autonomy. Perhaps even more significantly, an evolving social environment enables greater personal freedom and experimentation with roles and behaviors. The issues and challenges facing youth today are very different from those of their parents' generation and have far greater potential to influence health, with both short- and long-term negative outcomes.

In this age group, health-related behaviors account for 50 percent of a person's health status. Genetics and environment, including standard of living, each contribute 20 percent; access to traditional health services accounts for only 10 percent. The most serious, costly, and widespread health problems are all potentially preventable. In addition, unhealthy behaviors established during these years set the foundations for many chronic diseases that cause death and illness in adults.

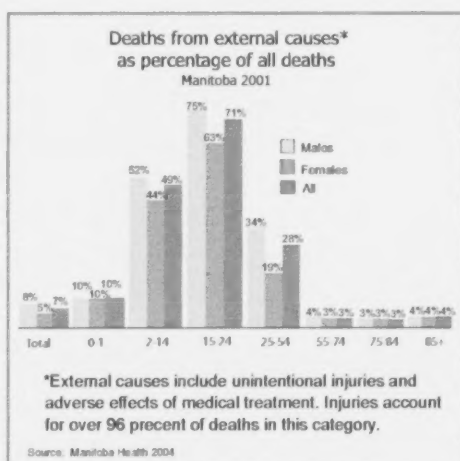


Investment in the current and future well-being of young people is crucial to the health of the regional community.



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Labor force activity Population aged 15-24			
		Manitoba	South Eastman
Males	Participation rate	68%	74%
	Unemployment rate	11%	4%
Females	Participation rate	66%	69%
	Unemployment rate	12%	7%



This population has received relatively little attention from the health care system. Young people aged 15 to 24 years are low users of mainstream health services. There are few services directed specifically to this age group, and those services available tend to focus on problems, rather than promoting healthy behaviors and lifestyles.

Investment in the current and future well-being of young people is crucial to the health of the regional community.

Statistical background

Demographics

Young people aged 15-24 years form a significant and growing proportion of the South Eastman population (15 percent). The age group now numbers over 10,000 and is growing at three times the provincial rate. They represent a distinct population group with unique health issues and health care needs.

South Eastman's population aged 15 to 24 increased 25 percent between 1998 and 2008. Within the region, the age group 15 to 24 is projected to increase a further 26 percent by the year 2015 – more than doubling the projected provincial increase of 12 percent.

Education attainment for South Eastman young people is below average for Manitoba, while participation in the labor force exceeds the provincial level.

While many members of this age group are still completing their education, comparisons show that the proportion of South Eastman young people lacking a high school completion certificate (52 percent) is above average for Manitoba (48 percent). South Eastman residents aged 15-24 are also less likely to have achieved

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post-secondary qualifications, particularly at the college or university level, with 33 percent having only a high school completion certificate, compared to 36 percent and 41 percent for Manitoba and Winnipeg, respectively.

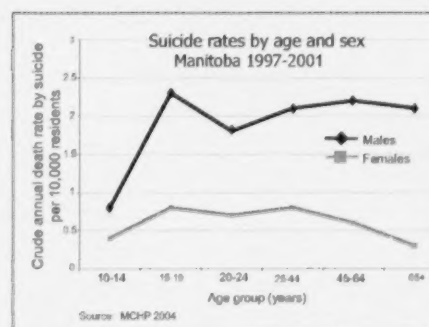
Health status

Unintentional injury, primarily from vehicle accidents, is the leading cause of death for people aged 15 to 24. A high proportion of accidents are alcohol-related. In 2001, injuries were responsible for 71 percent of Manitoba deaths in the 15 to 24 age group. Injuries also accounted for approximately 16 percent of hospitalizations among young people aged 15 to 19 years and nine percent of hospitalizations among those aged 20 to 24 years. Injury rates are much higher among men than women.

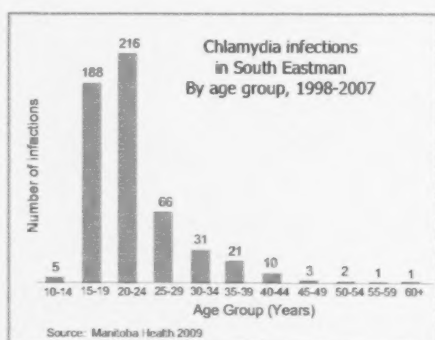
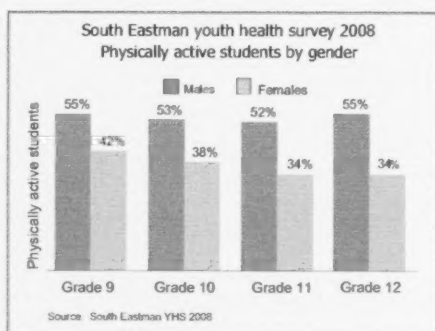
Teen drivers (15 to 19 years) have the highest fatality rate of all drivers. There is also a higher risk for passenger deaths in vehicles driven by teens relative to older drivers, particularly with two or more passengers and when the passengers are also teens.

In Manitoba, as elsewhere, alcohol continues to be one of the most significant factors contributing to serious motor vehicle accidents. Provincially, alcohol is a factor in 37 percent of fatal crashes where the presence or absence of alcohol can be determined and is most common among 20 to 25 year old victims.

Suicide is the second leading cause of death in this age group. For the period 1997 to 2001, annually across all age groups, males committed suicide more than three times as often (2.0 per 10,000) as females (0.6 per 10,000). When the available risk factors were considered, the key factors predicting suicide were: being male; being diagnosed with a mental illness in the previous year; being young; and having poorer health.



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From 1997 to 2001 in Manitoba, there were 4,160 suicide attempts not resulting in death (832 per year) across all age groups. Females attempted suicide twice as often as males (10.4 versus 5.7 per 10,000 per year). For both sexes, rates were highest among young people aged 15 to 19 and 20 to 24.

Young people aged 15 to 24 are more likely to report suffering from mental illnesses than any other age group. Half of all life-long mental disorders start by 14 years of age, and three-quarters by 24 years of age. The most common mental disorders in the 15 to 24 age group are anxiety, depression, and substance abuse. Young people are less likely than adults to seek professional help for mental health problems.

Two or more mental disorders frequently co-exist. It has been estimated that amongst children and adolescents who experience a mental disorder, over two-thirds (68 percent) have two or more mental disorders. Similarly, a recent study of adolescents with substance use disorders found that over three-quarters (76 percent) had anxiety, mood, or behaviour disorders at the same time.

Health-related behavior

Health-related behavior includes smoking, alcohol and other drug use, physical activity, nutrition and weight, and sexual activity.

In the 2008 South Eastman Youth Health Survey of students in grades 9 to 12, 22 percent of males and 17 percent of females reported that they smoked. Smoking rates increased with grade level, with 32 percent of Grade 12 students currently smoking. Fifteen percent of all students surveyed indicated that they had used illegal drugs in the past 30 days; the figure rose to 19 percent in Grade 12. Twenty-one percent of students

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were rated physically inactive, with inactivity rates much higher among females than males. Twenty percent of males and 14 percent of females were considered overweight. Only 12 percent of students were rated healthy eaters.

Reproductive health and teenage pregnancy remain concerns. The proportion of South Eastman young people aged 15 to 19 who have had sexual intercourse is consistent with the Manitoba figure, 40 percent, with the average age at first sexual intercourse around 16.

When measured across two, five-year time periods, 1996/97-2000/01 and 2001/02-2005/06, the Manitoba teen pregnancy rate for 15 to 19 year olds fell from 46 to 36 per 1,000. Rates also fell in South Eastman, which demonstrated the lowest rates for the province in both time periods (28 per 1,000 and 26 per 1,000, respectively).

Nevertheless, teen pregnancy is cause for concern in South Eastman. Teenagers as a group have significantly higher complication rates both during pregnancy and during delivery. Teen pregnancy also has long term health implications. Failure to complete education places teen mothers and their children at risk for low income, poor nutrition, poor housing, depression, and ongoing emotional stress. Loneliness and financial dependence can make teenage mothers vulnerable to involvement in unhealthy relationships that can, for example, result in domestic violence. Children born to teen mothers are more vulnerable to neglect and abuse and to adverse social, emotional, and learning outcomes from inadequate parenting skills.

While rates of sexually transmitted infections (STIs) are low in South Eastman, STIs are very highly



As in the rest of Manitoba, teen pregnancy rates fell in South Eastman between the two, five-year periods 1996/97-2000/01 and 2001/02-2005/06. South Eastman demonstrated the lowest rates for the province in both time periods (28 per 1,000 and 26 per 1,000, respectively).

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It just seems like it is a quick in and out. And you are not really sure of the diagnosis or the advice you are getting. Just because there are so many patients and so few doctors, it is just kind of trying to quickly get everybody through just so you can give everybody a little bit of attention.

My wife was already having a miscarriage . . . We weren't even scheduled for a follow-up meeting with the doctor. I was expecting more of a thorough examination . . . If the miscarriage was already diagnosed right then and there, she shouldn't have gone through that week of bleeding and all that.

I go to my family doctor sometimes, but it doesn't really make sense if you have to wait two months for an appointment then you forget what your question was.

concentrated among 15 to 24 year olds. At particular risk are youth living in urbanized settings and in communities closer to Winnipeg.

Young people aged 15 to 24 are very low users of mainstream health services, including family physician services. However, for South Eastman's targeted Child and Adolescent Community Mental Health Program, current service demands are considerably greater than the program's capacity to respond.

Consultations with youth and young adults

Community consultations underscore a wide range of issues and barriers to health and health care among South Eastman youth and young adults.

General issues and barriers to health and health care

General issues and barriers to health and health care for young people include the following.

- **Lack of access to basic medical services.**
For youth and young adults, basic health care is physician, walk-in, and emergency room care. Youth and young adults report significant problems securing physician care, concerns about long wait times for appointments, and feeling that they are rushed through consultations.
- **Lack of access to health information.**
Young people are keenly interested in health information and want ready access regarding questions of immediate concern. They are clear that traditional means of providing information do not succeed with their age group.

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- **Mental health.**

Youth and young adults consider mental health an issue of considerable concern for many members of their age group. The consultations revealed service gaps and challenges, including program-based barriers, for young people needing to access mental health services.

- **Expectations of health care.**

Young people have concerns about their expectations of the health care system and the sense that these expectations are often not met.

- **Practical barriers to health services.**

For youth and young adults, finances, transportation, and the remoteness of some rural communities represent significant practical barriers to health care and health.

Specific issues and barriers to health and health care

Youth and young adults also face a number of significant health issues and barriers that signal the unique health experiences of the important developmental years from age 15 to 24.

- **Sex education and reproductive health issues.**

Pregnancy, sex education, and reproductive health concerns are major health issues for youth and young adults, particularly females. Overcoming barriers to accessing information, treatment, guidance, and support represent crucial needs.

- **Addictions.**

Problems with addictions represent a significant and growing issue among youth and young adults in South Eastman. Major problems relate to substance abuse but pornography and video

In crisis, the crisis line is open to all community members. However, the program can only actively do assessments on youth 15 years and older. So, for example, if a youth calls and states that they would like to be seen by the mental health team they need to be 15 years old. And if they're not, they are re-directed to call McDonald Youth Services or present to a hospital. There is nothing for youth under 15 unless they are referred through the community mental health program, but that is not a quick process.

Another thing that frustrates youth is that there is a different age of consent for service underneath different acts. Child and Family is mostly 18 and younger and in health care it's 16 or 14 years and younger to receive services on their own accord. That is very confusing for people.

We span so far of an area with all these small little towns that it can be very isolating. These young people are the ones who suffer in silence. They don't have transportation, and they don't know what is available.

I had my sex ed class when I was in grade 4. They were pretty much telling you this is what a boy looks like, this is what a girl looks like – all that stuff. Nothing about condoms or anything or pregnancy.

When I did the sexual education sessions at the school, I brought up about the addictions on gambling and pornography and, as I was talking, the number of uncomfortable 'how did you know?' eyes that were shifting around was amazing! It's everywhere, so why not here?

Chapter 4: Health in special South Eastman populations - youth and young adults

People who are seeking information need to know that what they are doing is confidential, and I think a lot of young people are a lot more nervous about that than older people.

I have homeless clients who couch-hop around the community because there's really no place for them to go . . . But they do want help, and they do want to talk about it – they want some education. They deserve a place to sleep and a meal. That is another huge unmet need in the area where a lot of our youth are living like that.

You almost have to be aggressive with them before they decide to do something with you.

gaming are emerging areas of concern. The consultations highlighted a lack of resources to deal with youth addictions.

- **Confidentiality.**

The preservation of confidentiality is a vital aspect of service delivery to youth and young adults.

The consultations underlined the importance of maintaining confidentiality about young people's health issues and protecting the privacy of their personal information.

- **Transitioning from childhood to adulthood.**

Young people shared perspectives reflecting their transition between childhood and adulthood and generally feel that their health needs are distinct.

Attitudes and traits consistent with the transitional time of youth and young adulthood can greatly influence lifestyle and health-seeking behaviors. Transitions from child-focused systems to adult health services may pose significant health barriers, particularly for young people already experiencing major problems.

- **Homelessness.**

The consultations underlined South Eastman's increasing but largely unacknowledged issue of homelessness among youth and young adults.

The health service delivery system is very poorly equipped to deal with this problem.

- **Ageism.**

Young people perceive that their youth weighs against them in how they are treated by the health care delivery system. Service providers also observe that young people attempting to access the health system frequently encounter prejudice and are at-risk for differential care.

Chapter 4: Health in special South Eastman populations - youth and young adults

Recommendations

The consultations identified a number of recommendations to assist the RHA to work better with communities to improve the health and health care experiences of youth and young adults.

1. Improve access to basic health services.

Youth and young adults asked for increased access to the basic health services they seek most frequently, including family physician, walk-in clinic, emergency room, and mental health services. The consultations also called for greater focus on youth-appropriate health services, particularly mental health and overall health promotion. As well, service providers identified gaps in services for families, including parenting resources beyond early childhood into the adolescent and teen-raising years.

2. Provide health information in alternate ways.

Young people asked for better access to health information and advice for their age group and shared a variety of potential strategies including better use of telephone and internet technologies.

3. Acknowledge transitioning needs.

Young people's health needs change dramatically over the transition period to adulthood as they establish their independence and make crucial lifestyle decisions. Youth and young adults wish that the challenges they face were better understood and supported. Immigrant youth and young people living non-mainstream lifestyles feel especially vulnerable to lack of community supports.



Over the transition period to adulthood, young people's health needs change dramatically as they establish their independence and make crucial lifestyle decisions.

Chapter 4: Health in special South Eastman populations - early childhood



Early childhood is a key period for growth and development.

4. Examine options for service delivery specific to youth and young adults.

Young people see the need for more responsive health services for their age group and offer suggestions to improve access and effectiveness. Service providers advocate keenly for services dedicated to youth and young adults and, in particular, targeted teen clinic services. Many young people also see the need for targeted services, particularly immigrant youth and young people living non-mainstream lifestyles.

5. Develop a community-based approach.

Service providers believe strongly that the RHA should take a community-based approach to service provision for youth and young adults and develop working partnerships with other services and organizations.

4. Early Childhood (0-6 years)

Early childhood is a key period for growth and development. During the early years, from conception to age six, there are crucial periods for brain development that establish a foundation for learning, behavior, and health over a person's entire life. Children develop by interacting with their environment and people who surround them – parents, siblings, grandparents, childcare providers, friends, neighbors, and more. Supportive communities, which are safe, secure, and provide access to programs and services for families with young children, make a significant contribution to healthy child development.

Early brain development is rapid, dramatic and interactive. The brain of a newborn baby contains billions of specialized nerve cells called "neurons" that are ready to form quadrillions of connections in order

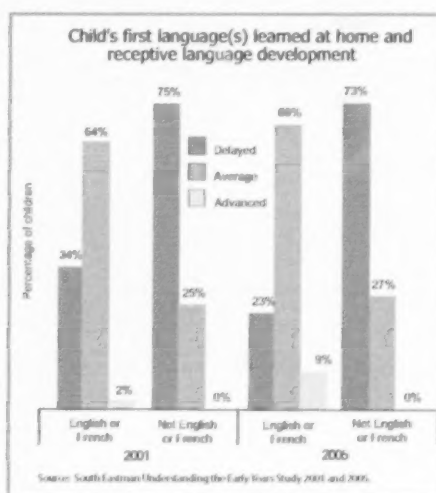
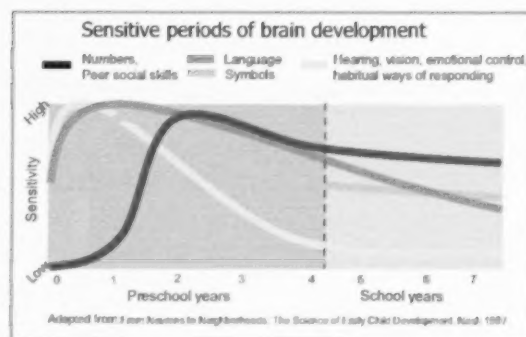
Chapter 4: Health in special South Eastman populations - early childhood

to function effectively. Areas of the brain that are repeatedly stimulated and supplied with information in the early years of life become a permanent part of the brain. Complex working connections develop among neurons; however, areas that are not used frequently are eliminated and will not be restored. Connections between neurons are pruned. These processes are sometimes referred to as the “sculpting” of the brain.

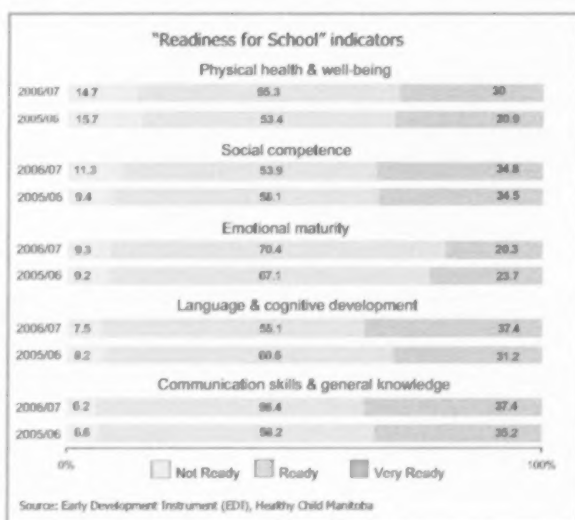
There are pre-programmed “sensitive periods” in brain development during which specific areas of the brain “turn on” and become ready to receive environmental stimuli. During these sensitive periods, neuron-to-neuron connections are sculpted to establish specific abilities – cognitive (language and learning), sensory, muscular, emotional, behavioral, and social. The quality of early experiences also influences the brain’s ability to think and regulate bodily functions.

The first years of life from conception through to six years of age set the foundation for long-term health and well-being. Healthy children form the foundation of healthy societies. Early child development and economic growth and prosperity are strongly linked.

Access to local-level information on early child development helps communities see how their young children are faring and judge their successes and challenges in supporting children and families during the crucial early years of life. South Eastman’s Understanding the Early Years (UEY) research project has provided local information to families, communities, service providers, and the RHA to guide and strengthen learning, information-sharing, and action on behalf of the region’s children.



Chapter 4: Health in special South Eastman populations - early childhood



Not Ready – bottom 10%

According to a normal distribution, one would expect 10 percent or fewer children – ideally none – in this percentile category. Overall, South Eastman had a small percentage of children not ready for school. However, in physical health & well-being and social competence, there was a higher percentage (more than 10 percent) of children "not ready".

Very Ready – top 30%

One would expect at least 30% of children in this percentile category – ideally more. Across most domains, except emotional maturity, South Eastman had a large percentage (more than 30%) of children "very ready" for school.

From 2001 through 2007, South Eastman was one of thirty-three communities across Canada taking part in the unique population-based UEY. The project had two principal components: the school survey and the community survey.

The UEY project demonstrated how local research can be applied at a community level to motivate change. Over the seven-year span of UEY, more than 1,000 families, five school divisions, and 250 service providers participated to develop an understanding of how children are doing in their first six years of life. UEY also created a legacy of partnerships, networks, and tools that have carried on since the project ended in 2007.

The study population comprised kindergarten children living in South Eastman. The sample size doubled between 2001 (365) and 2005 (795) with the participation of an additional school division. Data collection in 2005 represented all school divisions within South Eastman.

The gender ratio remained unchanged over the two time periods, with boys representing 51 percent.

Research findings

Overall, South Eastman children were rated in excellent or very good physical health.

Research data provided evidence of gender differences.

- Boys were twice as likely as girls to exhibit aggressive and hyperactive behaviors.
- Girls scored higher in readiness for school learning.
- Girls scored higher in emotional problems and passive aggressive behaviors.
- There were no gender differences in vocabulary development.

Chapter 4: Health in special South Eastman populations - early childhood

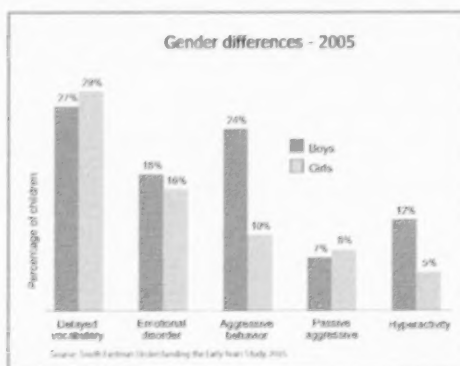
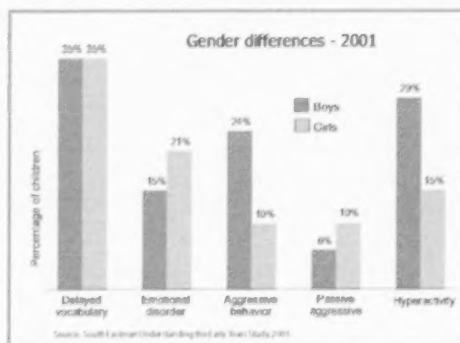
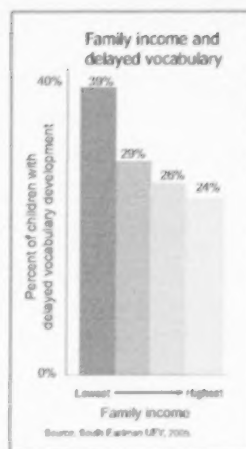
Place of birth and first language(s) learned at home affect vocabulary development. Children born outside of Canada and those who did not learn to speak English or French in the home were two to three times more likely to experience vocabulary delays in terms of school readiness.

The majority of families had at least one working parent. Children with at least one working parent were less likely to experience delayed vocabulary development, emotional problems, and hyperactivity. The percentage of children living in families below the low-income cut-off (LICO) was constant at 12 percent for the research period. Children living in low income families were more prone to experience delays in vocabulary development and less likely to participate in early childhood activities such as organized sports or lessons. The average household income reported by families decreased from \$60,257 in 2001 to \$55,273 in 2005.

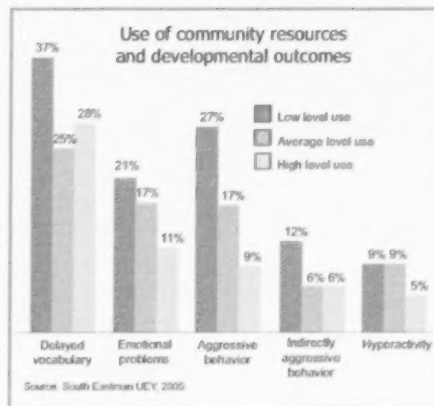
South Eastman parents generally rated their neighborhoods as positive places to raise children; however, they felt that they did not have adequate facilities for children and were unaware of programs available. They rated the following as "good to very good" – safety and cleanliness of neighborhoods, families with children, schools and nursery, and actively involved residents. Conversely, they gave ratings of poor to fair on adequate facilities for children, presence of health facilities, and accessibility to public transportation.

The oft-referenced African proverb "it takes a village to raise a child" recognizes that children live in families and families live in communities.

– From McCain, M. N.; Mustard, J. F.; & Shanker, S. *Early Years Study 2: Putting Science into Action*.



Chapter 4: Health in special South Eastman populations - early childhood



The UEY study looked at the relationship between child development and the use of community resources (educational, cultural and recreational). Children were classified into three categories: low level user; average level user; and high level user. Low-level users of community resources were more likely to be classified with delayed vocabulary development, emotional problems, and problematic behaviors.

Parents were also asked about their reasons for not using community services and programs. These reasons were grouped into the following three categories.

- **Situational:** those arising from one's own life circumstances.
- **Institutional:** practices and procedures that hinder people from participating.
- **Dispositional:** attitudes or beliefs towards program or service.

Between 2001 and 2005, percentages of South Eastman parents reporting 'institutional' barriers to program use declined, while percentages reporting 'situational' barriers increased. This highly positive finding suggests significant progress on the part of service providers in improving access to services by creating new programs for younger children, expanding existing programs, and adjusting times to make it more convenient for families to attend. However, there was a slight increase in the mention of high program costs and lack of awareness as reasons for not using community resources.

Reasons parents confirmed for not using community services or programs (%)

Client group	2001 No. of children: 365	2005 No. of children: 795
Situational		
Not enough time	32.1	33.8
Unaware of programs	24.9	32.0
Health reasons	1.6	2.3
Institutional		
Too costly	26.0	30.6
Program times not convenient	27.1	24.2
Programs not age suitable	37.5	26.2
Commute difficulty	24.4	21.5
Program of interest unavailable	48.6	36.1
Program not in preferred language	6.3	4.6
Not enough spaces	3.0	3.5
Dispositional		
Concerned about safety	5.5	2.7
Concerned about quality	4.4	4.7
Cultural or religious reasons	2.5	2.6

Chapter 5: Primary health services

Primary health services form the basic underpinnings of South Eastman's regional health care system. Service availability, accessibility, and quality determine the ability of regional health care to improve population health status, both current and future.

Background

Levels of health services

Three levels of services describe medical care that is becoming increasingly complex.

Primary health services are the first point of contact with the health system for the care of common illnesses and management of ongoing health problems.

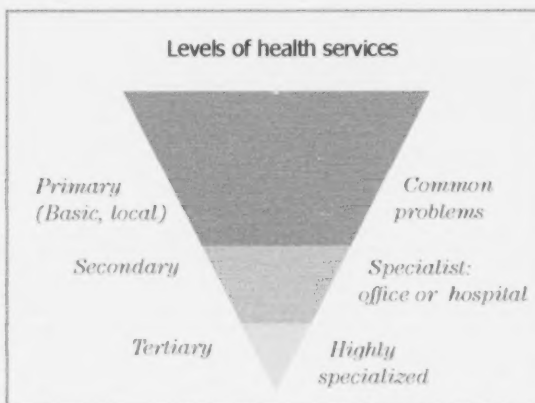
Secondary health services address more complex health problems and are provided by specialist physicians and other specialized health professionals.

Tertiary health services are highly specialized diagnostic and treatment services. Patients are referred by community hospitals or physicians. Tertiary health services require specialized service providers, sophisticated equipment, and support services, which are available only in dedicated expert centres.

Primary health services

Primary health services are the most familiar of all health services – where people turn first when they have a health problem or question.

The core primary health service provider is often the family doctor but may also include a variety of local health professionals whose services can be accessed directly, without need for referral by a doctor. Examples include family doctors, emergency room doctors, nurses, home care workers, mental



Chapter 5: Primary health services



East Borderland Primary Health Care Centre is one of two such centres in South Eastman. The second is in Niverville.

health workers, paramedics, therapists, social workers, dietitians, pharmacists, chiropractors, and dentists.

Primary health services take care of common health problems and manage ongoing illness. They are the most basic and essential of all health services and are provided at the local community level. Primary health services also represent the gateway through which other, more specialized health services are accessed.

Primary health care approach

Across Canada, there is agreement that the delivery and organization of primary health services need improvement. The *primary health care approach* is one of the strategies used in Canada to improve local access and service delivery. The *primary health care approach* recognizes that family physicians, nurses, and other professionals working in teams offer improved service access, greater patient satisfaction, and better overall health outcomes. All on-site services are accessible through any team member ("one-stop" health care access). In addition, health professionals working as teams coordinate clients' overall health needs, assist with health system navigation, synchronize follow up, and provide preventive health care.

In South Eastman, the *primary health care approach* has been adopted as the service delivery model for primary health services at the community health centres in Niverville and Sprague. For South Eastman, the *primary health care approach* applies only to a fraction of primary health service delivery. More than 90 percent of primary health services are delivered in traditional ways by programs that often operate in isolation from one another.

Chapter 5: Primary health services

Community consultations

Introduction

Between September 2008 and April 2009, the regional health authority in South Eastman conducted an extensive series of consultations about primary health services. People participated in focus groups, discussion groups, and interviews and included:

- community members from all four planning districts;
- primary care physicians working in medical clinics and emergency rooms;
- primary health service providers specifically engaged in the primary health care approach to service delivery; and
- a range of other primary health service providers.

In total, there were 112 participants: 59 community members; 13 primary care physicians; 16 primary health service providers working in primary health care centres; and 24 primary health service providers working in other locations.

Consultations sought participants' responses in four areas.

- How do you define primary health services from your perspective?
- What do you see as issues and strengths in South Eastman's primary health services?
- What are the barriers that stand in the way of primary health services in South Eastman?
- How can the RHA in South Eastman work with communities and providers to strengthen primary health services in the region?

Participants spoke from their own perspectives and experiences and in their own words about the

Chapter 5: Primary health services

Primary health services mean looking after health in the community. Primary health means things that are common versus the specialty group – it involves looking after the general health of the population.

I think the key is keeping the client as the focus rather than your role and your job.

I'm comfortable with a doctor that knows me, and I'm not about to change that for someone that doesn't know my history.

Physicians need to be the patient's advocate, and we know the system. We know what is accessible, and we know what isn't, so we can say to our patients, "You should be getting this" or "You shouldn't be getting that." And if they say, "I thought it was normal to wait six months to get my colonoscopy." I can say "No, you should be able to get it done sooner."

If I try to remember 25 years back, there has been a great improvement as far as senior citizen services and home care which we didn't have before. There has been a terrific improvement, quite a change.

The region has done well. I think there are a lot of strengths – there are good things. We had problems with ER overcrowding; the region did some good there, found creative ways of doing things that have freed up a lot of staff time. The region has responded to some of the challenges.

primary health services in the region, contributing their knowledge, opinions, personal stories, and recommendations.

Findings

1. Understanding of primary health services

Health care providers are generally agreed in their characterization of primary health services.

For health care providers working in and with the community, the principles and values of the *primary health care approach* are familiar and integral to the way they routinely provide services.

Community residents leave no doubt that they see the primary care physician as key to accessing and receiving appropriate health care.

Family physicians are aware of their pivotal roles in the primary health service system and take their responsibilities very seriously. They recognize that residents depend on them not only for access but to assist with advocacy and system navigation.

2. Strengths in primary health services

All stakeholder groups perceive considerable strengths in the regional primary health service system.

Residents across all South Eastman districts appreciate the services available in their communities.

Physicians also speak positively of the primary health service environment in South Eastman.

3. Issues, gaps, and barriers in primary health services

a) Access to physician care

The issue foremost in residents' minds is access to physicians. Even more problematic than getting to see

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a physician is securing consistent medical care over time.

Although community residents use primary health services in various ways, the family physician represents the main entry point to the health service system and the principal source of health care and health information. Many people have problems obtaining physician care when they feel it is needed.

Physician shortages and high turnover lead many people to feel that the notion of having a family doctor who gets to know them, understands their health history, and helps them with their health decisions is an ideal no longer possible to achieve.

Southern District residents report contrasting experiences accessing services through both the Manitoba and United States health care systems.

b) Population growth, increasing system demands, and diminishing resources

In South Eastman, access to all primary health services has been progressively limited by exceptional growth of the regional population. This growth, compounded by increasing demands for expanded services throughout the health care system, has steadily eroded the availability of regional health care resources.

Primary health service providers feel the increased pressures very keenly. Many consider that steadily rising workloads and service expansion jeopardize quality of basic care.

Within South Eastman, the relative shortage of family physicians is a constant challenge. This has adversely affected use of emergency room services and increased local reliance on walk-in medical clinics.

You are a regular but the doctor isn't a regular! You come and see a doctor today and next week, if you need to see the doctor again, you see someone different and have to come back in three weeks. You never really get to know them.

We have what they call the best of both worlds. When my father-in-law got really sick, we took him to Roseau [Minn.] The doctor right away knew what was wrong, and he called an ambulance. The doctor went with him, and they had a doctor in the city waiting for him immediately. It would have never happened if we went to [community X]. I really hope that this is never taken away from us.

The biggest issue is manpower – it's the most important one...it's all the positions that look after primary health care. It's difficult to provide consistent primary care when limited by the availability of the resources for it.

In ER, we are seeing more and more people because there are not enough family doctors. A lot of people are accessing primary care through the emergency room.

I saw the pressure that was on that walk-in clinic when there were people who were literally lined up out the door trying to get in. Walk-in services need to be looked at, including whether they can be offered in different locations.

There used to be steady doctors there. Nobody wants to stay anymore as they can't do anything, except treat for minor stuff. They can't deliver babies or do minor surgery. So they don't want to come to a small town . . . They use it as a stepping stone to get into somewhere else where they can use their training.

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Another thing that's taking place is the expectations on physicians and the health care system and what they can and should provide. You used to smash your finger, say "Ouch," and move on. Now they want X-rays and further evaluation. Expectations have increased.

Will there be resources to deal with a bunch of extra patients that get added on if we truly do the job that we should do in screening and identifying the majority of the diabetics and the majority of the early cancers? We are going to start requiring more laboratory services if we really do the sort of follow up that's recommended by Canadian guidelines. We are going to be using a lot more resources. We need to hear, if we are going to identify more people with disease, that we are going to be able to treat them.

At the clinic, we have actually started to collect data to see what our wait times are so that, if there is an intervention, we can actually see whether it works. I find that very exciting to be able to say, "Okay, here is my wait time. Let's put in a diabetes education nurse and see what the impact is, not just on quality but on wait times."

To be honest, up until now I didn't realize that the public health nurse did all of that. I assumed that at the age of 18 months they were done with you. I didn't realize that she was the community health nurse. I saw her as someone to check up on my child.

If people knew what we did, I think it would make things much smoother.

With new services that are in place, sometimes physicians are not advised of these. People take it for granted that we know, but sometimes we are not aware.

For many community residents, the walk-in clinic represents a disagreeable and unsatisfactory means of accessing medical care.

Some community members have questions in regard to current service delivery structures.

c) Increased expectations of health care

All stakeholder groups clearly recognize that societal expectations of the scope and responsiveness of health services have risen substantially over time.

Regional health care is therefore facing, on one hand, increasing societal demands and system expectations and, on the other, decreasing capacity and limited resources. Residents and providers alike recognize this dichotomy.

Physicians point out that emerging technologies and early detection tools and protocols are also increasing expectations and workloads.

At the same time, physicians are more confident that they are able to collect and track better information to enable decision-making at the medical and system levels.

d) Awareness of available primary health services

Despite widespread community perceptions of limited access to primary health care, many residents are unaware of the full range of primary health services available in their communities. In addition, many health care workers are unfamiliar with services available to complement the care they provide.

While residents are highly familiar with the medical services available in their own and neighbouring communities, knowledge of community-based services, such as mental health and public health, tends to be quite limited. Not only are many people unaware that

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these services are available locally, but their nature and functions are often poorly understood.

Among health care providers, the public's lack of knowledge about primary health services is a frequently voiced concern.

Awareness is also limited among many primary health service providers, including physicians.

e) Information supporting individual responsibility for health

A consistent theme across regional communities is the desire for greater individual ownership and personal control over health. Key to this, residents believe, is access to health information and education.

People often need health information and, while most recognize more than one route of access, the physician is most often seen as the definitive source. Problems arise when the need for advice and direction is perceived as urgent. Overall, it is generally felt that communities need more information and education on health and health services.

Residents seek health information frequently and from a variety of sources. Nevertheless, physicians are seen as the ultimate authorities and the path to answers on health concerns often leads, even via other health providers, to the medical clinic or emergency room.

Many people believe that they could better manage their own health if they could get information when they need it, especially when the need seems urgent. Frequently, they need only advice and direction, but help is hard to come by, especially outside office hours.

Residents generally consider that all communities need better access to health information and education, particularly around prevention and health

If I just want to get information on something I am wondering about, the [Inter]net is obviously my first run at it. Next to that, I guess, is the family doctor.

Having somebody who is almost like a switchboard, like an operator to sort of consult and tell me what should I do. This operator could say, "Call this person or that person." That idea is very appealing. So, who do we call at two o'clock in the morning?

The RHA needs to expand their thinking on how to get the information out to the people in the community. So people can recognize and take ownership over their own health too. People are still responsible for themselves. But I think if you give them some more knowledge they would take responsibility.

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A patient will come to the facility, and they don't even know why they are there. They just know that they have an appointment. So they don't seem to have the information initially about what the procedure is or where they are supposed to go. There seems to be a gap.

There are barriers within and between programs. It takes a lot of creativity and flexibility in service delivery to address access issues. I see that between proctor services and home care – they will say to me that they don't do that; it's a proctor's job. And I think, "Why can't they do both of those jobs? They are in there bathing someone. Can't they give them their medication?"

I was wondering about nurse practitioners as part of the primary health care picture . . . I was thinking, for rural communities, of a nurse practitioner who could prescribe medication and who is available on short notice for an infection or anything like that. It might be a good alternative if there is a shortage of physicians.

Some of the things that we are doing as physicians, we could spend our time more effectively doing other stuff. A lot of the chronic disease care could easily be done by nurse practitioners.

promotion, and that information on regional health services should be easier to find.

f) System communication, navigation, and service integration

From the community's perspective, the health care system often seems fragmented and poorly coordinated. Health care workers recognize that internal program and service barriers contribute to the situation.

Residents perceive significant barriers to communication among the various parts of the health care system. These stand in the way of service coordination and make it very difficult for people to navigate the health system.

Many service providers understand how intimidating and confusing the health care system can appear to its clients.

A matter equally troubling to service providers concerns the dynamics at play within and among programs and services. These may also raise barriers to communication and service integration.

g) Innovative, alternative, and collaborative service delivery

There is general agreement among all stakeholder groups that strengthening primary health services involves considering different service models and structures based on greater collaboration and alternatives to physician care.

Many residents encourage looking at different methods of service delivery as one of the strategies to enhance local access. There is considerable support for nurse practitioners, increased use of non-physician primary health providers, and more flexible hours of operation.

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Reliance on family physicians as the gatekeepers to service is commonly agreed to present many challenges. Communities are clearly willing to look at moving beyond this service model.

Primary care physicians see a definite need for more collaborative service models with the regional health authority to promote better communication, service integration, and client care.

Physicians are mindful, however, that a number of systemic barriers must be overcome in order to deliver services differently.

Other health care providers also recognize a need for greater collaboration between programs and services and among the various decision-making levels within the regional health authority.

All stakeholder groups believe that electronic health records represent potentially important resources in enabling greater collaboration and service coordination.

h) Access to mental health services

Access to mental health services is a major issue for all stakeholder groups. They identify several factors that operate to limit access, including lack of awareness of the services available, stigma associated with mental illness, and funding constraints.

Many residents are concerned about the general lack of awareness of mental health services in their communities.

Other factors, including the stigma associated with mental illness, challenge individuals and families in gaining access to the mental health services available in their communities.

Doctors are preoccupying themselves with kinds of tasks that they shouldn't have to do. Regarding this gatekeeper idea . . . I think in some sense they want to do some of these things which they shouldn't be doing.

We [doctors] would like to work with nurse practitioners where we can hire them. But if we can't bill for doing that, we are less likely to do it. Something in the funding model would have to change for us to have nurse practitioners. We are absolutely convinced they would be extraordinarily busy.

We all practice in our silos. Money's been wasted and gaps have been further widened because we're not working together.

The major obstacle to that is no information is shared. We can't do that until we have electronic health records. This is essential to moving forward in streamlining patient care and services. This will be a huge investment but the payback will be worth it.

I never knew you could access mental health services in [my community]. I just assumed if you wanted counselling then you had to go to the city . . . If that information could be made available . . . I don't even know how accessible it is.

Drug abuse and mental health go hand in hand. They are closely connected.

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You have a patient that comes in and needs psychiatric referral. Well, you can spend two to three hours on the phone trying to organize it, and then they end up in Thompson or The Pas because there aren't any beds anywhere else. They don't have access and nobody wants them.

People can't understand. When they talk about remote, they think way up north in the Northwest Territories or somewhere, but we are way more remote than a lot of the other people are.

One of the things that we really hit on is the fact of the community working together because we do have a voice. But we also have to be realistic that the RHA has limited resources. We can ask all we want but the RHA can't fund us if they don't have a funding base of their own. So we have to provide a pretty strong case and some solutions.

I am a strong supporter of [the primary health care approach] but if the centre is not set up physically, or with the people involved so it integrates them, then it won't really be [the primary health care approach]. I am thinking about Niverville. I don't feel like there is a linking or any kind of a relationship between providers. Maybe they do behind the scenes, but as a patient I don't feel it's there.

All stakeholder groups recognize that there are significant problem areas where needs are not being met, but these require programs and services, e.g. addiction services, for which South Eastman's mental health program is not currently funded.

Primary care physicians advocate for improved coordination between medical and mental health services in the region. They also underline the need for greater access to resources available only beyond the region.

1) Geography and remoteness

Many residents, including a large number of older people, live in small, rural communities remote from major centres. Locally, health care is delivered from small service sites. These residents face particular challenges to access the full range of primary health services.

For members of isolated communities across South Eastman districts, "smallness", distance, and lack of transportation present the biggest, practical hurdles.

Many residents of small communities believe that they need to be more active in order to be heard by the RHA and, in some instances, view their role as lobbying local government for better health care.

Community members also point out that a number of consultations have already taken place. The time to action seems unreasonably long.

4. Experience with existing primary health care centres

In South Eastman, community health centres in Niverville and Sprague are taking the *primary health care approach* to service delivery.

The comments of residents who use the centres reflect general appreciation of easier access, although some hesitancy around service integration is evident.

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Front-line primary health care centre staff, ground-breakers in developing and implementing the *primary health care approach* in South Eastman, see benefits for their communities and the service provider teams.

Recommendations

All stakeholder groups believe very strongly that the RHA should move to address the issues, gaps, and barriers in regional primary health services.

The groups made a number of key recommendations, advising the RHA to focus on strengthening primary health service access and delivery while increasing the dialogue with all South Eastman stakeholders and initiating a strategic, intentional approach to primary health care in the region.

1. Strengthen basic primary health services

a) Adopt practical approaches to systemic challenges

All stakeholder groups recognize that the delivery of primary health services is challenged by a variety of factors, including systemic barriers, funding, and geography. They understand that quick fixes are not available but express a strong desire to move forward.

Physicians and health care providers urge the RHA to be practical and solution-focussed in implementing strategies to strengthen basic primary health services. As plans are made, they encourage decision-makers to more clearly understand what is happening at the front-line of service delivery

b) Re-examine the structure of service delivery

Community members are very clear in expressing their readiness to look at accessing other health care options, including reducing reliance on primary physician care. Service providers, including primary

It's a great thing as a front-end staff person if the client can access a range of programs through one building. They can come to one place – they don't have to go far. That is an awesome thing.

If you are always acknowledging that there are resource challenges and nothing is happening, then you get tired. A decision has to be made whether we can continue at this pace. If not, then we need to cut back and not do this program until we can actually do it properly.

We feel the RHA is committed to excellence. We want to deliver the best health care possible. We just want to make sure that, if we are identifying problems, something can be done about them.

We need to have funding for nurse practitioners. But there's the other whole issue of physician extenders – physician assistants, authorized. That's what we need.

The managers and the people on the front line, they live in different worlds.

There are systems they have now where you can go to a place, they video the thing, and the doctor at the other end examines the video and makes the diagnosis. It seems to me that solves a lot of the problems. People don't have to travel because they can come locally. Again we would need a nurse practitioner here or someone who could talk to the doctor and do anything that maybe had to be done, in terms of blood pressure and what not. But I think the technology is there for that now; it is just a matter of putting it in.

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You know, I really like the idea of the primary health centre so that when I have a problem there is absolutely no question who I call first. That concept is wonderful because I think that so many times we feel lost. I know for myself I have not sought help because I wasn't sure where to go.

We have a lot of services; it's just educating the public in what we have.

One thing that would be good for physicians is knowing what the actual services are in our region, medical access, what they are. It can be a little bit frustrating not to know within psychological or mental health what actual services they offer.

Just have one number to call and have an easier way to find programs. We have lots of people saying, "Where are you in the phone book?"

Even raising awareness of the DHAC [District Health Advisory Council], because I'm sure 95 percent to 98 percent of the people don't know that there are people here who are supposed to be our regional advocates at board level.

I think too that we need to try and educate the community as to the services we do not offer. I think in our three years here, we've probably had to call 911 six or eight times. We are not equipped like an ER.

health care physicians, identify the need and their own willingness to re-examine how services are delivered and by whom.

The consultations also recommend better use of innovative strategies such as technology and mobile services to meet the needs of smaller, more remote communities.

c) Consolidate and coordinate services around the client

Community residents, primary care physicians, and health care workers advocate strongly for bringing the range of primary health services together around client needs and delivering services in an integrated fashion.

d) Provide more accessible information on regional health services

All stakeholder groups advise the RHA to look at ways of more effectively informing residents and health care providers about the range and availability of services in the region. In some cases, information is available but many residents find it confusing or unhelpful.

Primary care physicians also ask for help in knowing and understanding the RHA services available and how best to link their patients to achieve appropriate care.

Community members also recommend that the RHA examine various information channels and assess which might work best, including integration with a range of existing local sources of information.

Service providers recommended that the RHA specifically focus on ensuring that residents are linked to appropriate information.

e) Be responsive to specific local needs

All stakeholder groups urge the RHA to understand and acknowledge community diversity and respond to

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the unique needs of the different communities that make up the region.

In communities where physician services are provided by contract, residents recommend that the RHA take action to increase continuity of care, regardless of physician turnover.

2. Strengthen the dialogue with stakeholders

All stakeholders consulted ask for greater involvement in finding solutions to the day-to-day challenges of delivering basic primary health care in the region.

a) Strengthen the dialogue with communities

Community members consistently feel that their views and needs are not sufficiently acknowledged. They want to be heard by the RHA and participate actively in health care planning.

b) Strengthen the dialogue with physicians

Primary care physicians feel very strongly that lack of ongoing two-way communication over years has created a gap in understanding between the RHA and physicians and has blocked the way to potential partnerships in service delivery. A number believe that recent progress has been made.

Physicians ask the RHA to include them as active participants in health planning and to continue to provide opportunities for regular, purposeful conversations.

c) Strengthen the dialogue with front-line service providers

Front-line service providers perceive that they have little involvement in health planning, yet feel that they have a great deal to contribute. Staff ask to be included and heard in helping to problem-solve organizational issues and service delivery barriers.

Some things that work in one facility may not work in another. We need to be sensitive to the needs of the area. We have quite a diverse population in the region.

Manage care in the outlying areas directly. For example, manage the [contract] doctors' offices. Put [RHA] office staff in there. Contract the doctors to work a certain number of hours and do the booking for them so they are being used for the entire time.

The RHA, do they come out to communities like [ours] and hold their meetings? They need people around the table to listen to this kind of stuff. These decision-makers need to hear this first-hand instead of hearing it third-hand from you and listening to these consultations.

A lot of the physicians would agree that things have improved considerably. If people think they are being listened to, they feel much better. We know that it [the RHA] is a large organization, and there are systemic barriers to getting things done. The RHA doesn't have all the answers – it's systemic.

There is no direct communication between the physicians and the Board. That's okay sometimes, but sometimes it's good to hear from the Board directly and the Board to hear directly from the physicians. Not to make it onerous for them or us, but there are certain issues – issues of significant size and scope, such as physician retention and building projects.

Sometimes the efforts of the staff are not recognized by managers – the extra hours of working are expected, and it leads to more stress on families and unhappy staff. Actually listening to the staff and collaborating together as a team not to have all these fragmented pieces. It could be as simple as [management] listening and saying thank you.

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You need to take all the players and evaluate how primary health care service can be streamlined to make it better . . . We have region-wide committees for maternal/child and other services, but we are not focusing on the primary health care approach and on getting better delivery. I think that is a paradigm shift that all the program managers need and that all the committees need. We need to work on getting the basics better first.

We say here [primary health care centre] that the client is the primary focus. What is the best thing we can do for the client? Then you kind of break down the barriers.

Unless we start working with the physicians and get them on board, the [primary health care approach] model will never get off the ground, at a team level or at a regional level.

We should be looking at doing more things in collaboration with other primary health care workers.

All of us in the region – from the field workers all the way up to management – need to start practising the principles of the primary health care approach.

3. Develop the vision and action plan for primary health care

South Eastman health care providers, including primary care physicians, who took part in the consultations were familiar with the *primary health care approach*, while discussions with community members were framed around the concepts of one-stop local access, team approach to service delivery, and service coordination.

All stakeholder groups agree that strengthening the *primary health care approach* to service delivery in South Eastman offers considerable improvements in access to basic health services, client satisfaction, and health outcomes. Stakeholders are not clear, however, as to the vision and plan to achieve these goals in the region.

Stakeholders offered the RIIA a number of recommendations for developing the vision and plan for primary health care.

- Actively position the client at the centre of service delivery.
- Develop a working model with primary care physicians.
- Remove barriers to the *primary health care approach*. This includes facilitating resource-sharing among and between programs, providing a focus on outreach, and recognizing that the necessary cultural and program shifts require intent and resources.
- Recognize that the *primary health care approach* is collaborative.
- Involve the community. Staff of primary health care centres, experienced in the development and implementation of the *primary health care approach*, stress the importance of involving community in planning. Communities are unique – there is no one-size-fits-all formula.